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# THE AMERICAN PRACTITIONER.

SEPTEMBER, 1879.

Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than anything else.—RUSKIN.

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## Original Communications.

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### GASTROTOMY FOR RELIEF OF INTERNAL STRANGULATION OF THE BOWEL—EXTENSIVE SLOUGHING OF THE INTESTINE—RECOVERY.\*

By J. N. McCORMACK, M. D.

*Formerly Resident Physician to the Cincinnati Hospital, Corresponding Secretary of the Kentucky State Medical Society, Etc.*

I was called May 15, 1878, in consultation with Dr. A. C. Wright, to see R. W. S., an intelligent, moderately well developed American farmer, aged thirty-four years, who had been suffering for twenty-four hours from acute obstruction of the bowels.

Thirteen years ago, after returning from a day's hunt, he reached down from a high door for a fowling-piece, and catching the hammer of the gun on a step, discharged the full load of shot through the penis and right testicle into the region of the pubic bone on the right side. The larger quantity of the charge passed outside of that bone, and ranging upward buried itself in the muscular tissue in the right side of the hypogastric and the right inguinal regions. After several

\* Read before the Kentucky State Medical Society in 1879.

days the remains of the right testicle were removed, and later a plastic operation was performed for the cure of a fistulous opening in the urethra. He made a slow recovery, without any indication of peritonitis, and enjoyed good health until three years ago, when he began to have occasional attacks of "colicky pains" in the right inguinal region, attended by constipation of the bowels, and usually by a well marked globular swelling in the affected region, which hitherto had been relieved by the administration of a brisk cathartic, warm applications and mild kneading externally. The intumescence had always disappeared with a distinct gurgling sound, followed by an action from the bowels and immediate relief. These attacks had become more frequent and severe in the last few months, and for the last ten days the patient had suffered almost constantly from an aching in the bowels.

The last attack came on twenty-four hours before the time of my visit. Dr. Wright was called in, and found the patient in much pain, vomiting frequently, and with a distinct firm tumor which, except that it was hardly so prominent and was situated higher up, had much the appearance and feel of an inguinal hernia. Under warm water injections and soothing applications externally, the larger part of the swelling disappeared, but without relieving the vomiting and pain. An anodyne gave him rest during the night.

When I saw him the pulse was 80, temperature 98.5°; he had vomited frequently during the morning. Although active purgatives had been given and enemata often used, he had had no motion from the bowels. The pain was not severe, although there was excessive tenderness over the affected region. The patient was placed under the influence of chloroform and a careful examination made, externally and through the rectum, without eliciting any additional information. Inversion, injections, mild purgatives and soothing applications were faithfully tried without benefit. In the afternoon the vomiting ceased, and he passed a night of comparative comfort; with the morning came a return of the vomiting. There was no apparent change in the swelling and tenderness



over the abdomen. Pulse 90; temperature 99°. Copious warm injections, through a tube introduced into the colon, were again tried, bringing away no fecal matter at any time. The afternoon again brought comfort, but late in the evening stercoraceous vomiting set in, and continued through the night. On the following morning the pulse was 100, temperature 99°; countenance anxious and expressive of great suffering and prostration; the vomiting was frequent and very offensive. Except that the swelling was not so hard, its condition was unchanged.

The patient was placed under the influence of chloroform, and assisted by Drs. Wright and Porter, I proceeded to operate by making an incision five inches long, beginning an inch below the umbilicus and extending downward in the median line. After exposing the peritoneum and stopping the oozing of blood, that membrane was carefully slit up with a probe-pointed bistoury. Many small shot were found in the muscular and subperitoneal tissue. The intestines were agglutinated together and to the abdominal wall by an abundant recent lymph, and the small intestine lying in the line of the incision was of a dull darkish gray color, and being deprived of the support of the abdominal wall, ruptured from the slight pressure exercised by its contents. This coil was gently drawn out at the wound, and a large quantity of fecal matter discharged through it. After breaking down the recent adhesions on the right side a strong old band of false membrane was found, passing across and firmly constricting the lower portion of the ileum and the ascending colon. This was divided, the gangrenous portion of ileum placed in apposition with the external wound, which was then brought together in the usual way, an opening being left at the lower angle of the wound for the discharge of feculant matter and for drainage. The patient rallied well after the operation, and under the influence of an anodyne passed a good night.

*Second day.*—Countenance bright and hopeful; no vomiting since the operation, and very little pain; pulse 96, temp. 98°; fecal matter wells up along the whole line of the incision;

antiseptic and disinfectant dressing kept constantly applied to the wound; the tongue is almost clean, and the appetite is good.

*Fourth day.*—Has rested well; pulse and temperature normal; takes all the liquid diet that is allowed him with avidity. The edges of the wound are beginning to gape, and the fecal matter passes freely not only along the line of the incision, but also through the apertures made by the sutures. The plaster renders no support to the sutures, as it is loosened as soon as applied. Abdominal cavity frequently and carefully washed out with tepid carbolic solution.

*Eighth day.*—Discharge very abundant and offensive; general condition good. I removed the sutures, and finding the bowel lying in the wound to be puffy, black and offensive, I removed about six inches of it with the scissors. The edges of the wound were now brought into apposition with the quilled suture, and supported by an abdominal corset, a large opening being left at the lower angle for drainage.

*Tenth day.*—About twelve inches of intestine, with mesentery and some fat attached, came away through the opening this morning. This portion of intestine was in a better state of preservation, especially the central part of it, than that removed two days ago, and its structure was distinctly recognizable. The discharge from the bowel indicates a pretty good digestion, and this is confirmed by the increase in the flesh and strength of the patient.

*Twenty-fifth day.*—The wound has healed by granulations from the ends, leaving the artificial anus in the center. A catheter passed into the opening goes directly into the right inguinal, where the ileum no doubt terminates.

*Sixtieth day.*—The patient has been able to walk about the house for the past three weeks, and in the last few days has been riding on horseback. The discharge from the artificial anus is involuntary but not continuous—four to six hours often intervening between the passages. Mr. Martin, of this city, has constructed for me a hard firm pad, to which is attached an adjustable gum-bag, which entirely protects the

person and clothing from the discharge, and gives great comfort.

*Seventy-fifth day.*—Ten days ago the patient felt a desire to have an action from the bowels *per viam naturalis*, and after taking an enema passed off a free, healthy-looking stool, and two days later he had two other good passages in the same way. Ten days later and nothing more passed by the rectum; but the patient finds that when he takes an injection by the wound it frequently passes off by the rectum, and *vice versa*.

One year has now elapsed since the operation was performed, and my patient's condition is exceedingly gratifying. He travels in his carriage or on horseback without difficulty, and is able to engage in light work. Sometimes for ten days together he has regular actions from the bowels in the natural way, little or nothing passing through the artificial opening; and then probably for an equal length of time nothing is passed by the rectum. The most reasonable explanation for this condition of things, to my mind, is that after the operation the mass of gangrenous bowel was encysted as it were by organizable material, and when it was thrown off a cavity was left, into which the two ends of the bowel opened, and from which there was also a communication with the orifice in the abdomen. Whether or not the communication will ever become sufficiently and reliably free for all the fecal matter to pass into the colon, and to allow the artificial opening to be closed, is a question time alone can determine; but the probabilities are that it will not.

Such is the brief history of a case that has much in it of practical interest, chiefly in the result, as bearing on the question of the propriety of surgical interference in this class of cases. That they are usually allowed to die, after the use of the "conventional cathartics, enemas," etc., and that they are not of infrequent occurrence, an examination of the literature of the subject shows but too plainly.

After speaking at length of the ordinary treatment, Gross concludes by saying:—"As to the propriety of enterotomy

in such cases, the question presents great difficulties. Of these the most important are, the nature of the disease, and the fact that the division of the peritoneum is always attended with extreme risk to life, especially when it is severely congested, if not actually inflamed. . . . In two instances in which, after mature consultation with eminent physicians, interference was deemed advisable, I signally failed in conferring the slightest benefit by these procedures, one patient dying at the end of four hours and the other in less than thirty-six. I have myself no taste for this kind of interference. In internal strangulation, depending upon intussusception, a twist, or the interception of the bowel by an aperture in the omentum, the diagnosis is so uncertain that the proper time is usually allowed to pass before an operation is agreed upon, and when, at length, it is performed, the case must, almost of necessity, speedily terminate fatally."

One is struck at the similarity of this teaching to that of the older authors, in regard to ovariectomy and the Cesarean section. Phillips is certainly sufficiently conservative in saying that "the operation is justifiable when three or four days have passed without any relief from ordinary means, constipation being complete, and vomiting of fecal matter continuing." Erichsen, writing since the disappearance of the unfounded prejudice against opening the peritoneal cavity, says:—"If, however, by attention to any of the points which have been pretty fully adverted to, it can be satisfactorily made out that there is an internal strangulation, and more especially if the intumescence occasioned by it can be felt, it will evidently be the duty of the surgeon to give the patient his only chance by the division of the stricture."

That the mortality following the operation has been high, is as might be expected from the nature of the trouble it is designed to relieve; but that death is generally due to the destructive changes that take place while we are "waiting for something to turn up," and not to the operation itself, and that the inflammation of the peritoneum will not only not increase but positively diminish, when the strangulation which

caused it is removed, is clear to my own mind. Of fifty-seven cases collected by Ashhurst, one by Marsh, of London, three months ago, and the one now reported, making fifty-nine in all, thirteen recovered. When it is remembered that in all the operation was resorted to only after extreme delay, and that the thirteen recoveries had the patients not been operated on, would certainly have died, the result is by no means discouraging.

My thanks are due Drs. Wright and Porter for assistance at the time of the operation, and for their hearty coöperation in the after-treatment.

BOWLING GREEN, KY.

#### FIVE CASES OF TRICHINA SPIRALIS, WITH REMARKS.

BY E. P. GILPIN, M. D.

On December 2, 1878, I was called in consultation with Dr. Becknell, to see five members of the family of Mr. George Brumbaugh, who had all been taken sick a week previously.

CASE I. The mother, aged forty years, was affected suddenly by cramping in stomach and bowels—the pain being neuralgic in character and intermittent; there were also diarrhea and vomiting. On examination we found the tongue reddened and dry, with prominent papillæ. There was moderate fever, temperature  $101^{\circ}$  F., muscular soreness and distinct hyperesthesia.

CASE II. A son, aged nineteen years, had only slight pain, no diarrhea and no vomiting, but was markedly edematous about the face, more especially the eyelids, and complained of a weak and sore condition of the muscles. The tongue was moist and furred. No fever.

CASE III. A daughter, sixteen years old, was affected much like the mother, but a majority of the symptoms were more aggravated from the inception, and her condition appeared to be worse at the

136 *Five Cases of Trichina Spiralis, with Remarks.*

time of examination. The muscular soreness, however, was limited to but a few muscles. The temperature was 102° F.

CASE IV. A daughter, eight years old, was affected quite similarly to Case II, but she had considerable diarrhea, and at the time of examination neither of these had been confined to bed.

CASE V. A little girl of five years; had profuse diarrhea, some vomiting and moderate pain in abdomen; a very general edema; persistent and complete muscular soreness and hyperesthesia, with a temperature of 103° F. An apathetic condition was a noticeable feature of this case alone.

*Remarks.*—The skin in all the cases was dry; urine slightly decreased; the evacuations resembled milk and eggs beaten together, odor very offensive.

The general appearance of Case III was that of a typhoid fever patient in the third week, excepting that she had more strength. Hers was the only case that showed emaciation, and she was of slight build.

We agreed readily on the diagnosis, but not having a microscope at the time we were unable to verify our opinion. Two days later the cases passed from Dr. Becknell's care into the hands of an irregular, by whom they were treated during three weeks.

On the 23d of December I was called to take charge of these cases. The course of four of them had been an aggravated continuance of the symptoms already detailed; but the mother had died, at the end of the fourth week of her illness, with every appearance of lung fever, according to the nurse, who is an intelligent and observing lady. Case III had menstruated once during her illness.

The original diagnosis was reasserted, and a very unfavorable prognosis was given in Case V, which was verified twenty-four hours later, death occurring from a failure of action in the respiratory muscles. An autopsy was not allowed, but I obtained small pieces of muscular tissue from five widely separated muscles, and in each specimen, under the microscope, found large numbers of the trichina spiralis; in seve-

ral specimens numbering twenty-five hundred to the square inch, or more than one hundred and fifty thousand to the cubic inch. These were in every position, from a perfect coil to a straight line.

Cases II and IV progressed favorably under treatment; their convalescence being marked by an increase of urine and perspiration, and a ravenous appetite. Neither now complain of any ill effects.

Case III, after a gradual emaciation and loss of strength, a total lack of appetite and a persistent diarrhea, which I was unable to control, died January 26, 1879, from inanition.

An autopsy was held twenty hours after death. There was extreme emaciation. The brain was not examined. The larynx and bronchi showed the effect of catarrh. The left lung was normal; the right showed moderate hypostatic congestion, and was adherent to the pleura throughout its whole extent. The adhesions were unlike those of a recent pleuritis, being dry, and although complete were easily broken. The heart was flabby, with slender fibrinous clots extending from the left ventricle. Fluid in pericardium was normal in amount and appearance. The stomach bore marked evidence of prolonged congestion, as did also the intestines throughout their whole extent; both were empty. The liver was slightly congested in one lobe only, being otherwise normal in appearance. The spleen was smaller, darker, and of firmer consistence than normal. The left kidney was considerably congested, and contained a small calculus in its pelvis. The bladder appeared unaffected, as did also the uterus and ovaries. There was no evidence of peritonitis.

Under the microscope, specimens of voluntary muscle from various parts showed from one hundred to five hundred trichinæ to the square inch; and each parasite was either coiled in its capsule or lying in the tissue adjacent to one, appearing as though it had been torn therefrom. The capsules were apparent to the naked eye, as small grayish-white specks. No trichinæ were found in the walls of stomach or bowels.



The treatment has been varied. During the first week, under the judicious care of Dr. Becknell, they received anthelmintics and laxatives, followed by a solution of glycerine, one part to three, together with a tonic and symptomatic course. Of the treatment during the following three weeks I know little, but understand that turpentine was freely administered to Case I. From that time on the treatment was mainly tonic and supportive, with anodynes, pepsin, etc., as needed, and nourishing food.

We were unsuccessful in our search for the source of the infection; and in the numerous specimens of pork brought to us for examination, we have thus far been unable to find any of the parasites.

To sum up:—My experience in these cases, so far as it goes, mostly tends to confirm previous conclusions, but there was one notable exception. Authorities speak of "profuse and persistent sweating" as one of the diagnostic symptoms; but in all these cases, on the contrary, *the skin was very dry* throughout the disease, becoming moist only as convalescence progressed.

If a narration of these cases should induce some of my fellow practitioners to re-read the literature of this subject, my object in reporting them will have been attained; for authorities all agree that an early diagnosis is of the first importance, as it is then only that we can hope to accomplish much by medication.

In regard to prophylaxis, I have found much satisfaction in reading the views of Heller, found in the third volume of Ziemssen's Cyclopædia; and in fact it would be hard to find a fuller résumé of the whole subject than is given by him in the volume cited.

Finally, treatment seemed to have but little permanent effect at any stage of the disease.

MILFORD, IND.

OBSERVATIONS ON ONE HUNDRED AND TWENTY-  
TWO CASES OF PNEUMONIA.\*

BY OSCAR T. SCHULTZ, M. D.

I have not mentioned icterus among the complications, although a certain degree of jaundice was present in the larger part of my cases, for I regard more or less hyperemia of the liver as an almost constant symptom in croupous pneumonia. The so-called "bilious" pneumonia of authors I have never seen.

The duration of the disease was from one and a half to nine days, defervescence being established in about three-fourths of my cases between the fourth and the seventh day, in a large number on the eighth or ninth, and in a few in thirty to seventy-two hours; none were protracted beyond the ninth day.

Of the twenty-nine cases observed in children none died; of the twenty-nine adults up to forty years, two; and of the thirty-six beyond forty years, six; or dividing the latter into those from forty to sixty years, and into those beyond sixty years, I find two deaths among the twenty-five of the first, and four among the eleven of the second class. Of the eight cases terminating fatally six were by collapse, brought about by exhaustion of the heart. Exhaustion of the heart was also present in a greater or less degree in a majority of the cases that recovered, and in a number of these developed as early as the second or third day, a fatal result being only averted by a prompt resort to analeptics. Deducting two fatal cases, which came into my hands on the seventh and fifth day respectively, and in one of whom collapse was fully established at the time, while in the other it became so within twelve hours, my rate of mortality was 6.5 per cent.

According to my experience, the prognosis for young or adult non-cachectic cases must be considered good; for cachectic and aged subjects bad; the more so when they have,

\* Continued from August No., page 97.

perhaps, passed through a bilious fever the autumn before. But there are two other factors which greatly influence our prognosis, and against which we country physicians have all more or less to contend; the one is the habit among our people of not calling in professional assistance until a disease has given evidence of not getting well of its own accord; the other the open condition of our sick-rooms, and their being heated by smoking fire-places. As for the first of these, experience justifies me in asserting that a pneumonia, coming under treatment the first twelve to twenty-four hours, can either be made to abort, by which I mean that the fever can be made to subside in about thirty to thirty-six hours after its commencement, and the resolution of the hepatization will take place without fever, or with perhaps a slight rise of temperature, about the fifth day; or if it can not be cut short in this way, that it can be made to run a short course, the fever terminating on the fifth, sixth, or at farthest seventh day. I might cite numerous examples to prove this fact. To illustrate the second, I will briefly report two cases, both of which came under observation during the present year.

CASE I. Woman, aged thirty-five years, consumptive, pregnant in ninth month; had passed through a croupous pneumonia in March, 1876, through an influenza in November, 1878. During the latter part of December bronchitis developed after exposure. January 2, 1879, she had a chill in the morning and another one in the evening. Examination on January 3 showed a croupous pneumonia of inferior lobe of right side; temperature  $102^{\circ}$ ;  $P_R = \frac{120}{42} = 2.8$ ; threatening abortion. The disease progressed well until January 5, when temp.  $99^{\circ}$ ,  $P_R = \frac{112}{38} = 2.7$ . Took cold the night following while out of bed over chamber, the outdoor temperature being  $16^{\circ}$  to  $20^{\circ}$ ; and on the morning of the sixth the balance of the right lung was involved. From this on the temperature was  $101\frac{1}{2}^{\circ}$  in the morning, and  $105^{\circ}$  in the evening. Signs of cardiac exhaustion became distinct during the night of the seventh. The dyspnea was considerable, and was aggravated into suffocative attacks by the smoke, which almost constantly filled the room. Stupor became developed by the ninth, and gradually passed into coma.

CASE II. Woman, aged twenty-four years, of good constitution; had a chill on February 17, 1879, followed by cough and light but continued fever. On the morning of the twenty-first there was another chill. When seen four hours later the temperature was  $99\frac{1}{2}^{\circ}$ , the pulse 88-96; respiration easy, scarcely accelerated, but painful. There was coryza, cough, with scanty, viscid, non-sanguinolent sputum, and intense pain in left side. An examination gave negative results. There was frequent bilious vomiting, with pain and gurgling in right ileo-cecal fossa, but constipation, with violent pains in limbs. On the twenty-second, temp.  $102^{\circ}$ ,  $\frac{P}{R} = \frac{108}{40} = 2\frac{7}{10}$ ; a left croupous pneumonia of typhoid character was diagnosed. By the evening of the twenty-fifth the temperature was  $99^{\circ}$ ; there was but little pain; mucous and submucous râles; sputum sanguinolent for the first time. During the raw and stormy night following, she was exposed to the draft from an insecure window; and on the morning of the twenty-sixth the temperature had risen to  $101^{\circ}$ , and there was stiffness over the whole body, with intense rheumatoid pains. On the morning of the twenty-seventh, extensive hepatization of the right lung was found, and the loose râles had disappeared from the left side. The temperature was  $102^{\circ}$ ;  $\frac{P}{R} = \frac{104}{40} = 2\frac{6}{10}$ ; great dyspnea, stupor with muttering delirium. The temperature remained at  $102^{\circ}$ ; the pulse-respiration ratio varied from  $\frac{2}{1}$  to  $\frac{2}{1}\frac{4}{10}$ , with severe dyspnea and obtunded sensorium, until March 3, when the temperature was normal,  $\frac{P}{R} = \frac{98}{52} = \frac{2}{1}$ . By the next day the defervescence had remained complete, the pulse-respiration ratio was still  $\frac{2}{1}$ . Convalescence progressed favorably.

In the treatment of croupous pneumonia, I have aimed at these ends:—First, to limit the disease; second, to treat the disease itself; third, to treat the fever; fourth, to prevent and treat exhaustion of the heart; fifth, to manage disagreeable or dangerous symptoms.

1. When called during the first stage of the disease,—the stage of engorgement,—I am confident that I have been able to abort the fever in the sense indicated above, or at least to shorten the length of the disease and to make it pursue a milder course. To accomplish this purpose, I administer drop doses of fluid ext. aconiti radice every hour, and twenty to thirty grains of the submuriate of mercury either at one dose

or in five grain doses, repeated every three hours. This treatment is persisted in until the twenty-fourth to the thirty-sixth hour after the chill. I do not claim that by this course of treatment I have been able to prevent hepatization,—at least to prevent an error in diagnosis. I have always noticed those cases which, though presenting all the general symptoms of incipient pneumonia—a chill, sudden and high rise of fever, pain in the side, cough with scanty and viscid expectoration—when subjected to the above treatment, did not at my next visit present the physical signs of pneumonia, as catarrhal fever.

2. Upon the principle that pneumonia is a general disease, with a local manifestation, and soon learning from experience that our cachectic constitutions would not tolerate debilitating remedial measures, I have avoided, in treating the disease, anything that would deteriorate the blood. In mild cases, without typhoid symptoms, and particularly in pleuro-pneumonia, I used the tincture of bryonia, in drop doses every two hours, throughout the whole stage of hepatization; and when resolution set in, combined this drug with expectorant doses of ipecac. Under this treatment these cases ran a remarkably favorable course. In cases where there was high fever, with but slight remissions, no diarrhea or diarrhea with grayish or greenish discharge, vomiting, considerable bronchial catarrh, in sthenic cases in adults and in almost all cases in children, I employed the submuriate of mercury in  $\frac{1}{8}$  to  $1\frac{1}{8}$  grain doses every two hours. Where there was marked bronchial catarrh, and when in the stage of resolution the bronchi were crowded with mucus, I administered antimon. et potass. tartr.,  $\frac{1}{8}$  to  $\frac{1}{2}$  of a grain every hour or two. That large class of asthenic cases, being so from the first, or becoming so in the course of the disease, I found to come to a prompt and happy termination under the use of phosphorus, given either as in Warner's compound pills of phosphorus, one pill every three hours; or where it was desirable to repeat the dose oftener, in the form of a tincture of phosphorus in drop doses, combined with  $\frac{1}{8}$  to  $\frac{1}{6}$  of a drop of fluid extr. nucis vomicæ.

3. Whenever the temperature did not rise above  $102^{\circ}$  during the first five or six days, and there seemed to be no imminent danger from cardiac exhaustion, the fever was left untreated, excepting that a nutritious diet and a small allowance of stimulants were ordered. This was the case in about one half the number of patients treated. When the temperature rose above  $102^{\circ}$  during the early part of the disease, or when the heart showed signs of failing, with a lower temperature, fifteen grains of quinia, in solution with muriatic acid, was given in the evening, and the dose was repeated if necessary in forty-eight hours. The effect of such a dose of quinia would invariably be a lowering of the temperature from one to four degrees. In no case was the fever cut short by a dose of quinia given before the fourth day of the disease, and in no case did a similar dose of cinchonidia sulph. at all affect the temperature. In all cases, where resolution had not set in by the fifth to seventh day with an almost normal temperature, a full dose of quinia was given on the evening of the fifth to seventh day, and the effect of such a dose was either to bring about a normal temperature with established resolution by the next morning, or at least an abatement of the temperature by the next morning; and after this the fever never rose again, but the temperature became normal on the morning following, being thirty-six to forty-eight hours after the administration of the quinia. I could bring numerous examples to prove these points, as I have watched this matter very closely, especially during the past year. When collapse had once become fairly developed, quinia seemed to me to hasten the fatal end.

4. The prevention and treatment of exhaustion of the heart forms an all-important part in the treatment of croupous pneumonia, especially with us, as very many of our patients seem to present, from one cause or other, structural degeneration of the heart. Of all the cases observed by me there were but very few that preserved the full hard pulse of pneumonia for any length of time. In very many cases the pulse was full, labored and slow—ninety to one hundred—for the first few days, and then suddenly, without any apparent cause, with

no higher rise of fever, became soft, wavy, one hundred and twenty to one hundred and forty, and perhaps intermitting. Another large proportion of my cases had this soft, rapid pulse, with unequal waves, from the first. Here prompt and energetic treatment is necessary, or the patient will go under. To prevent this cardiac fatigue I relied upon nourishing diet, eggs and milk and whisky, giving the latter in half ounce doses every two hours, in those cases where the fever is high and the previous history of the patients leads me to anticipate an early collapse. As soon as the heart showed signs of failing, I administered three to six grains of camphor every three to four hours until the danger was over. In cases in which the pulse was distinctly intermittent, digitalis proved valuable and was generally sufficient to cause this abnormal condition to disappear.

5. Under the treatment as delineated above, it has been but rarely necessary for me to treat symptoms. The pain in the side has been but rarely so severe or persistent as to make me order a turpentine stupe, a poultice, or a mustard-draft. Cupping, blistering and opium I have never been obliged to use for this purpose. The cough was but seldom violent enough for me to resort to narcotics; when it was very distressing, morphia or opium was freely used until it became easier. The vomiting which formed a prominent feature in the pneumonia of last February, yielded after twenty-four to forty-eight hours to mercury and ipecac. The sleeplessness, so troublesome in this disease and about which patients complain so much, I have always left untreated. In but few cases the diarrhea demanded special treatment; usually the alvine discharges became normal under the general treatment, and where this was not the case a few doses of opium with acetate of lead brought speedy relief. Collapse was treated by camphor, wine, whisky, and a large mustard-draft to the chest; but in no case, when it had once become fully established, have I been able to rescue the patient, although life was prolonged by these means for twenty-four to seventy-two hours. In general I have followed out the practice of treating symp-



toms in croupous pneumonia only where they actually seemed to exert an evil influence upon the course of the disease, or where by the great annoyance they give to the patient they undermine his power of resistance. If I anticipated no danger from either of these sources I have left them untreated, for it is my firm belief that too many of the measures adopted for this purpose tend to protract the disease.

Convalescence was usually prompt and uninterrupted. In some cases it became necessary to prescribe a tonic, in which case a pill of cinchonidia, iron, arsenic and gentian, brought good appetite and a speedy return of strength.

As evidence of the good results of my course of treatment, I append my mortality table, without which, as Juergensen correctly affirms, no report on pneumonia can claim any value.

*A record of deaths in ninety-four cases of Croupous Pneumonia, observed from May, 1875, to May, 1879.*

CLASSES BY YEARS.	No. Cases.	No. Deaths.	REMARKS.
0-16 years	29	.....	
16-40 years	29	2	1. Man, aged twenty years, with typhoid pneumonia, came under observation on seventh day in complete collapse. 2. Woman, aged thirty-five years, consumption, pregnant in ninth month; asthenic pneumonia of right side, lower lobe; on fourth day involvement of balance of same lung; uremic symptoms; death from exhaustion of heart on seventh day.
40-60 years	25	3	1. Man, aged forty-eight years, with typhoid pneumonia, right side; came under observation on fifth day in collapse. 2. Man, aged thirty-eight years, terminal pneumonia in phthisis.
60-87 years	11	4	1. Woman, aged seventy-five years, asthenic pneumonia. 2. Man, aged sixty-nine years; cachectic; had passed through a tedious bilious fever in autumn, in the November following typhoid pneumonia. 3. Man, aged sixty years; chronic heart trouble; complete cyanosis on third day, death on fourth. 4. Man, aged seventy-three years; pauper; came under observation on fifth day of the disease.
	94	8	

MT. VERNON, IND.

## REMARKS ON ALCOHOLIC STIMULATION.

BY DANIEL H. KITCHEN, M. D.

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From an experience of over ten years in the public hospitals and asylums of New York, and with the fact that alcoholic stimulation has been the producer of nine-tenths of all the disease under our care, we are led to make the following few remarks on the subject.

Intemperance is not a disease but a habit, and the irresistible desire for alcoholic stimulants is a self-engendered state, which, although it has become pathological, is only the result of the chronic toxical influence of alcohol.

If it can be proven that alcohol is not an efficient agent as a proximate alimentary principle, that it is not a heat-producing element when in the organism, and that it does not retard the constant wear and tear of all substance, its use is at once unnecessary and injurious. This abuse, when frequently enough repeated, becomes a habit; the habit a desire in which the craving has resulted from a self-imposed necessity.

Again, if it can be proven that alcohol does not possess the qualifications of an alimentary substance, a calorifacient, or a preserver of tissues, the irresistible desire can not but be an acquired state of the system—the result of changes in the cell structure of the organism. These changes, of course, constitute a pathological state, and as that can not, by the nature of the case, be traced to any congenital cause, it must be attributed to the toxical influence of alcohol.

The first question, therefore, to decide is,—Is alcohol an efficient alimentary element, and to what extent? There can be no doubt that this substance is capable of being absorbed, but whether it is consumed by the economy of the body, or

whether it is discharged unchanged by the various excretory organs, has been a debatable subject. While Perrin, Lallemand and Duroy confidently stated that the imbibed alcohol is eliminated by the skin, lungs and kidneys in its original form, they failed to determine the quantity, and their test-method with chromic acid has been found by Anstie and others to be unreliable. It is conceded now as absolutely certain that, as shown by Anstie's final experiments, the largest portion of alcohol, if taken in quantities insufficient to produce intoxication, is consumed by the economy, and only the minor part eliminated unchanged; from which we may safely conclude that when imbibed in larger quantities, portions of it at least are retained in the body, and there changed by vito-chemical action.

This being the case, reference may now be made to the position which the consumed alcohol holds from an alimentary point of view. When we consult the authors already quoted, and review their experiments, the evidence seems to be that alcohol is consumed and destroyed in the system, and it may be inferred that this destruction is attended with oxidation. But as oxidation implies a liberation of force only, and does not furnish in this case a corresponding supply of material to work upon, the consumption of alcohol becomes simply an excitant for increased chemical changes within the body, and of the material already existing. Its value, therefore, is more therapeutic than physiological, or, if no asthenic disease exists, an incentive to extraordinary physiological cell function, which is only another name for a symptom of toxic influence.

Dr. Parkes and Count Wollowiez have instituted minute inquiries in this direction, and the former has expressed his conclusions in the following words:—"It appears unlikely, in the face of these chemical results, that alcohol can enable the body to perform more work on less food, though, by quickening a failing heart, it may enable work to be done which otherwise could not be. It may thus act like the spur in the side of a horse, *eliciting* force though not *supplying* it."

Those who oppose this conclusion and endeavor to sustain their opinion by referring to more ancient records, which speak of diminution of carbonic acid, urea, etc., might profitably glance over Dr. Frazer's admirable analysis of Parkes's reports, printed in the proceedings of the Royal Society. These reports embody results of experiments made on individuals to whom large and small quantities of alcohol and brandy had been administered, as well as water, for their sole beverage; and after notes were compared, conclusions were arrived at which were so substantial that the worthlessness of alcohol as an aliment may be taken as established. In regard to marked changes in the vital processes almost negative results were obtained. For instance, it was found that the use of alcohol did not markedly modify the weight of the body when not used too long in large quantities; that it never lessened and seldom increased the temperature of the body, even when large quantities were administered. It was, however, found that two ounces of alcohol per day, in divided doses, increased the appetite, but that four ounces diminished it, and large quantities destroyed it; that it increased the rapidity of the ventricular contractions of the heart, thereby producing dilatation of the capillaries, and therefore a larger surface for interchange of elements between blood and tissues; that the amount of urine was slightly increased; and, finally, that the elimination of nitrogen from the kidneys and bowels was not diminished, provided the usual amount of nitrogenized food was taken.

Alcohol may excite the system to activity and restore for a short time a lost vigor of vitality, but it is unable to replace for any length of time other articles usually assimilated by the organism. When its use is long continued, the powers of assimilation become weakened and food can not be appropriated in sufficient quantities to support physiological life; and when such a condition arises, the craving for alcohol, although produced by its own toxic devastations, becomes a pathological condition—a state where a habit for alcohol is developed by an alcoholized system.

The second question, whether alcohol is capable of producing heat in the body, is inferentially if not explicitly answered by the experiments of the authors quoted. It is properly argued that alcohol being a hydro carbon, and classified chemically between the sugars and fats, undergoes combustion while being consumed, and that therefore it is a generator of heat. While this is not denied, it would be well to take into consideration the fact that this produced heat is a force expending itself on the over-activity which it produces in the tissues by rapidity of the heart's action. In other words, the inordinate vito-chemical interchanges produced thereby exhaust the fuel soon and entail a need for more, which, when not met by either food or more alcohol, will soon reduce the system beneath its self-calorifying capability, and lead to its suffering in a way the reverse of that intended. But abuse of alcohol reduces the powers of alimentary digestion, and less food is therefore appropriated; hence the system requires a substitute, and the victim falls again into that unfortunate state of self-engendered habit for alcoholic stimulants.

Aside from all arguments, we reach by experience the incontestable *fact* that its use does *not* enable man to endure a lower temperature than does the use of properly selected food. Dr. Hayes, of arctic celebrity, says that in the polar regions the administration of alcohol is not only useless but positively injurious. He further states that when circumstances arise under which its use seems imperative the succeeding reaction is to be dreaded, and that the immediate danger is only temporarily warded off. He, therefore, comes by practice to the same conclusion which has just been reached by theory, namely, that the increased vital action produced by the stimulus without an equivalent additional supply of food, or, in other words, without sufficient material to work upon, will induce a subsequent depression.

Does alcohol reduce the amount of wear and tear in the system? It has already been stated that the latest investiga-

tions have not revealed any diminution in the elimination of nitrogenous substances and carbonic acid, which are the evidences of wear and tear. Practical experiments also demonstrate that alcohol does not increase the power of enduring prolonged work or severe labor.

The results of Parkes's and Wallowicz's experiments may be stated as follows:—The heart of an adult makes about seventy-three and a half strokes in a minute, or in round numbers about one hundred thousand strokes in twenty-four hours, which has been calculated to equal in work the lifting of two hundred and sixteen tons one foot. They gave quantities of alcohol varying from one to eight ounces, progressively increased for days, and noted the increase in frequency of the pulse. On the ninth day, with one ounce of alcohol, the pulse beat four hundred and thirty times more than during a "water" period. On the fourteenth day, with eight ounces of alcohol, the increase was twenty-five thousand four hundred and eighty-eight; the heart during the alcoholic period doing a *daily* average work in excess equal to lifting fifteen and four-fifth tons one foot. After the alcohol had been left off, the heart showed how it had suffered from this strain by signs of unusual feebleness, and it took five or six days for the heart to recover its tone, as shown by the sphygmograph.

It has been sought to impress by the foregoing remarks that alcohol is of no value as an aliment in any physiological point of view; its effect is only pathological, toxic. It now remains to prove the connection of the pathological effects with the craving for more alcohol. This poison affects the system in three ways:—First, as an irritant to the mucous membrane of the stomach and other portions of the alimentary canal, by which a congestion of blood-vessels is produced, and consequently also a disturbance in the secretions of that membrane. In chronic cases the submucous structures become degenerated, and the organ of secretion either impaired or destroyed, so that the fluids which they should furnish to promote digestion become either vitiated or are entirely want-

ing. Hence the loss of appetite, the aversion to food, and the consequent asthenia, which seeks its relief in the stimulus which the system is most accustomed to, alcohol.

In the next place, alcohol after absorption stimulates the heart to rapid contractions and thereby quickens the rate of movements of the blood, and must of necessity impair the nutrition of every portion of the organism, and particularly, as I shall presently point out, the nervous system. Organic as well as inorganic chemistry shows that alcohol is a prominent agent in altering the chemical relations between compounds. In the system this influence is chiefly apparent in the large increase of the amount of fatty matter which alcohol produces in the blood, after being absorbed and forming a part of that fluid. The vitiated blood, together with the free alcohol which it may yet contain, affects all tissues and induces a destructive assimilation, reducing the nervous, muscular and areolar and all interstitial tissues to an almost lifeless, friable mass, resembling chemically a substance between fat and albumen.

The organs principally involved are those of the nervous system, the kidneys and liver. The diseases which have alcoholic intemperance so frequently as a cause—namely, cirrhosis of the liver and kidneys, Bright's disease, paralysis, hysteria, insanity, etc.—corroborate these facts. Of all the lesions, the disintegrations in the nervous tissue are the most significant. Alcohol appears to have a peculiar affinity for nerve matter. By its influence on nutrition generally, and by the power the nerves exercise upon the vital activity of each cell, all elective affinity within the cell wall becomes disturbed; and aside from a physical degeneration of tissues, a want of force is felt, which the sufferer thinks from unfortunate experience he can replace by a stimulus which has really produced this want of force.

Besides alcohol acts to a certain degree as an anesthetic, and as any feeling of want induces a painful sensation, that poison must come to the rescue. The effect of alcohol after an excessive and continued use is generally not confined to



simply abnormal sensations, but is directed, through the nervous channels, to the organs of the higher manifestations of man, and lessens his intelligence and moral control over himself. Now, when the higher seats of nervous action become involved, there is a feeling of depression in spirits—a compound of contrition, remorse and hopelessness, and described by those who suffer from it as by far more terrible than any physical pain arising from drink: this condition ends by the sufferer having recourse to what he knows to be his only sure relief—liquor.

This habit is a physical desire, created by the debilitating influence of the very article which will alone appease it. It is a morbid psychological condition dependent upon a previously induced physical degeneration of the system. It is not like other diseases which depend on an inherent germ, and are determined by contact with a proximate or exciting cause; not a malady due to natural forces. It is an acquired state, demanding as a therapeutic agent the very drug which has poisoned the vegetative and animal life of the individual.

The *diseases* and *deteriorations* produced by prolonged indulgence in this destructive agent are, many of them, so common and widespread as to be generally unnoticed from their extreme familiarity—affecting as they do in these days, perhaps, a *majority* of every community; many otherwise obscure conditions of disease being easily traced to this source. Alcoholic dyspepsia, vascular engorgement of the surface, sensory disturbances, such as buzzing in the ears and floating specks before the eyes, extreme thirst, premature signs of failing strength and diminished power of resistance, such as redness of the eyes, tremors of the muscles, clammy skin, husky throat, white-coated tongue, labored breathing and powerless heart, *tell even to the victim himself* their tragic story of enfeeblement and decay. There are, however, other trains of evil which the patient himself can not so easily recognize, and which are often when present thought to be due to other causes, and are only known in their final results on post mortem examination, unless detected and remedied

by a skilled physician during life, and their alcoholic causation pointed out.

Among the organic lesions (injuries to the structures of important bodily organs) may be noted:—Disease of the heart, disease of the blood-vessels, alcoholic consumption, diseases of the liver, diabetes, disease of the kidneys, cataract, sleeplessness from congestion of the brain, various nervous disorders and organic deteriorations of the substance of the brain and spinal cord, epilepsy, paralysis (partial or general), delirium and insanity, etc.

This frightful catalogue of bodily evils is no fancy picture; it is sufficient to say that alcohol is capable of producing, and does produce, all the evils I have related. It is also a well known and established fact among public men and administrators of the law that nine-tenths of all crime is committed after the use of some alcoholic beverage. Our large cities teem with hospitals and alms and workhouses, filled with victims of the abuse of alcohol.

We may now well ask ourselves the question, why do men drink? For many centuries our best and ablest physicians have been trying to solve the problem, and no doubt will continue until the end of time. But there are many causes which can and should be remedied. The cause of the desire to drink is not a physical cause but a moral one. Men drink because they like it; man has a fondness for the taste of liquor, and a greater fondness for the warming and exhilarating effect produced. We have met with scores of men and women who have been under our immediate supervision, and we have little doubt but it is the same with the greater portion of the human family, that drinking to excess is a pleasure. The effects on the mind and body soon become such that pain takes the place of pleasure. The restlessness and pain which is sure to follow the exhaustion drives the man back to his only infallible relief, the stimulant, thus gradually forming the habit before spoken of. The desire is as broad as human nature, and prevails largely of course among the vicious and depraved. What we must all deplore is its frequency among

the best elements of our national life—the deadly thralldom of its tyranny thrown over so many minds whose work and whose influence might be an example in their day. Look at it as we may, the tendency of alcohol is towards ruin and destruction—steadily downwards, physically, mentally and morally. The best and noblest men to-day are self-deluded under its influence: it is in its nature to conceal its disastrous effects from its victims foreordained; it vitiates everything—thought, action, emotion, all are tainted by it, even in the best and highest natures.

The abuse of alcoholic stimulants is too often attributed as a cause of social and domestic trouble, but from reliable statistics in our possession we are warranted in the statement that the reverse of the above is the actual fact. We have met with in public life hundreds of instances where domestic trouble was the prime starting cause for the use of stimulants among both sexes, and the criminal courts of this country show plainly enough that the major crimes and murders are committed under the influence of liquor after a domestic unpleasantness. Some of the brightest and best men and women it has ever been my lot to know have succumbed to the use of liquor under a *tyrannical and despotic home government* in which they lived.

And now what shall we say of the remedy or treatment of this habit for liquor? That a man came of an intemperate ancestry, would be an element in determining the degree of moral transgression which would properly attach to the habit in his particular case, and to the amount of pity or charity with which we might view his misfortune; but to say that he was not a free agent when he commenced, or that he is justified in continuing the same course indefinitely, is to introduce an element of poisonous and destructive sophistry into a subject sufficiently obscure. This excuse of heredity is too often a cowardly subterfuge, under which a purely idle and vicious self-indulgence seeks to escape the odium which justly attaches to a selfish vice. The blame which should attach to different cases varies very widely, but in no instance can I allow that

there should be any such unconditional absolution given as the plea of hereditary disease would seek to establish, and which it now claims by imputation.

Many persons, when they find the habit of drinking growing upon them, endeavor to moderate the pace at which they are running. In some cases this succeeds for a time, and they pass for moderate drinkers. Usually, however, the habit gains in power and the daily amount of alcohol is steadily increased, and eventually the decline in health, business or reputation is so palpable that it is evident something must be done. There is but one course to pursue, that is give up drinking altogether; *there is no such thing as a compromise*. It must be total abstinence or utter ruin, and to this must every one with an established alcoholic habit finally come. I say to any man who has had the misfortune of falling into this habit:—Leave your friends, your business for a time; place yourself without the reach of temptation. A few months will accomplish all; no matter how bad the case is, if a man has a desire to reform and the courage to make the attempt, he will succeed. Our profession can not cure intemperance; we can simply by our advice smooth the inebriate's pathway to health, and show him how he can go forth again with a strong body and a clear mind, with a will strengthened and disciplined, and confidence again restored in himself. The intemperate are a sensitive class, and we have this to meet and impress upon their minds that they have only fallen upon an evil from which many of the best men of this and all former generations have suffered. The disgrace is to supinely wallow in the mire into which they have accidentally fallen, instead of standing up like men and shaking off its entanglements. It is a singular circumstance that the men of brains, of brilliant imagination, of charming fancy, of sparkling wit, of noble aspirations and generous temper, should be so often stricken with this calamity. Men of talent, men of genius, or having the temperament of genius, have in all ages been prone to this weakness. This class are always worth saving, if it is at all possible.

Of course as medical men we can not advise even moderate drinking. Certainly there are a few who can drink moderately, but we are unable to point out that favored few. The dangers are so real and terrible, the advantages on the other side are so few and so delusive, that it is clear that *the safest rule is total abstinence*. There are no medical remedies for the appetite for liquor. We have no disease to treat, but man's moral nature to reform. We may secure sleep and relieve the unfortunate while under delirium, but we have no drug to supply the craving for whisky.

In a word, if a man does not desire to reform, we can not compel him. We may place him in confinement against his will, and in a short time he will devise a means to procure stimulants, even in many of the best regulated institutions. Our experience leads us to say that every man who makes a determined effort and places himself under the advice of his physician, will succeed, and in less than one year after beginning the attempt, by a willing and strict adherence to the rule of total abstinence, he may consider himself safely over the dark and dismal road.

NEW YORK CITY.

## FOREIGN CORRESPONDENCE—OUR LONDON LETTER.

LONDON, August 15, 1879.

MY DEAR YANDELL: The time for your letter comes round swiftly. And now that we have got some weather something like summer, we all feel lazy, and are dreaming of green pastures rather than desk work. And green pastures we have this year, and no mistake. Our wheat is very sadly rachitic indeed, and our potatoes are waxy. Our hops are just saved, and also the barley, so that there will be ale in England, even if we depend upon foreign countries for our bread-stuffs; a conclusion which may be less acceptable to the followers of Sir Wilfred Lawson than to the rest of the Britishers. For I don't mind taking you into my confidence, dear Yandell, but I have tried systematically the different non-alcoholic beverages, sampled them fairly, and, between ourselves, I have not yet found a fair drink among them, or anything to touch ginger-beer—that is at a reasonable price. And I do think, seriously and in all gravity, that if these temperance people are in earnest in their warfare on alcohol, they ought to be able to give us something in lieu of the time-honored beverages, to which they profess to have a rooted objection—something that will quench thirst without intoxicating. And I do not stand alone in holding that the very best thing they can do to put away our national liking for beer is to give us something equally good instead, at the same price. Is it not monstrous that we must pay for lemonade twice the price of a first-class expensive ale? And now when the long-looked-for summer weather is upon us, it is becoming, indeed, a burning question to know what to drink. However, perhaps the teetotallers will take the question up against another year.

R. Liveing has recently been discussing the subject of eczema of the palm, miscalled psoriasis palmaris. He holds that simple psoriasis rarely attacks the palm or sole, except in gouty subjects where there is usually eczema as well as psoriasis. He holds that the syphilitic form of palmar psoriasis should be termed a squamous syphilide, in order that definite distinctions may be made; but fears that the old phraseology is too well established to become obsolete. As to its treatment, he gives several reasons for its being confessedly

difficult. The position and mobility of the part is unfavorable to treatment; as fast as the skin heals it is rebroken by flexion and extension. This makes the treatment of chronic eczema rimosum in servants, and others who use the hands much, very protracted. Then the hands are frequently wet by washing or certain occupations, which makes the skin brittle and so retards the cure. In such cases india-rubber gloves are indispensable to cure. The next difficulty is that the cuticle of the palm is thick, and does not exfoliate readily, and the consequence is the products of inflammation do not readily escape, and the outer cuticle becomes thickened and brittle, so as to be almost horny, and it is necessary to the cure to get rid of this. Water dressing, lead lotions, or linimentum calcis, according to circumstances, are the local measures to be adopted; the gist of the treatment being never to let the dressing become dry. At the same time it is well to keep the bowels freely open. In the most obstinate chronic cases the different forms of lead or mercurial ointment should be applied, while the hand is rested, covered, and washed little, the ointment being applied continuously. Where the cuticle is much thickened, it may be necessary to remove it by the application, night and day, of a solution—four drachms of liquor potassæ to eight ounces of water. Rags wetted with this lotion should be kept on and covered with gutta percha. When the cuticle is perfectly macerated and white, it will peel or rub off readily. This should be carried on until the epidermis is reduced to its normal thickness; after which the treatment given above must be applied. Arsenic internally is often of great service.

A successful instance of Battey's operation has occurred under the care of Dr. Heywood Smith, in a woman of forty years of age. She had long been troubled with ovarian disturbance and uterine consequences. Being a poor woman, scarcely able to earn a living in consequence of her impaired health, she was willing to run the risks of the operation, which were placed clearly before her; and she eagerly pleaded for the operation. It was performed with the bichloride of methylene as the anesthetic, and under the carbolic spray. The right ovary was first found and removed, the pedicle being tied with "a fine double carbolized silk ligature," and then dropped back into the pelvis. The left ovary was then found after some little difficulty, and treated in a similar manner. "Neither oviduct was included in the ligature." Nine silkworm sutures were



passed through the peritoneum, but not through the muscles. The wound was dressed with three small bags of lint filled with carbolized disinfecting powder; over them four folds of thymol gauze; then eight folds of carbolic gauze, with waterproof, cotton-wool, a dry cloth, and strapping; and lastly a flannel binder over all. A morphia suppository (half a grain) was then introduced into the rectum, and the patient put to bed. The operation lasted forty minutes. The temperature rose that evening to  $101.6^{\circ}$ , but next day fell to  $98.8^{\circ}$ , and never after rose to more than  $99.6^{\circ}$ . Very little pain was experienced, and some colored discharge from the vagina followed for five days, with leucorrhea for three days longer. She made a perfect recovery. This case in all its details is highly creditable to Dr. Heywood Smith, and contrasts with the non-success of sundry other operators very satisfactorily. The right ovary was small, and weighed fifty-seven grains; the left weighed eighty-five grains. There had always been much pain in them; but there were no gross changes in them, so that they could scarcely be said to be diseased.

"Ovarian menorrhagia," is the title of a paper by Dr. Alfred Meadows, read before the Harveian Society some time ago. He explained that the term is not one as yet in common use, but is one that must soon take its place in our vocabulary. He holds the view that the ovary is the commencing point in menstruation—a view not held by John Williams, Mary Putnam Jacobi, and others. According to these latter authorities, there is a catamenial cycle which culminates in the menstrual week; there is a slow rise of arterial tension until the commencement of the menstrual week, when it rapidly falls. In fact that there is general vascular fullness preceding the menstrual flux, which is really a superfluous wave of nutrition that fits the female organism for the demands of pregnancy. According to this view ovulation may or may not occur with culmination of the superfluous wave, though usually it does. On the other hand, Dr. Meadows holds the older view that the vascular fullness of the ovaries is precedent to the vascular congestion of the uterus. Ovulation is accompanied by turgescence of the lining membrane of the uterus and fallopian tubes, and on this prepared ground the impregnated ovum finds a habitation adapted for its development. Certainly, the fact remains that there is a turgid mucous membrane during the catamenial flow. He says then "the

ovary is, as it were, 'master of the situation;' that it is in fact highest in physiological dignity and importance, and that the uterus, so far as menstruation is concerned, merely obeys the physiological behests of the ovary." Without agreeing with or differing from Dr. Meadows about this, his clinical observations as to the relation existing betwixt menorrhagia in many cases and conditions of ovarian disturbance are well worth listening to. We constantly, he observes, speak of "ovarian dysmenorrhea," where the pain is ovarian and not uterine, and must learn to regard many cases of menorrhagia as primarily of ovarian origin. He thinks that where there is too frequent ovulation, the periods occur too frequently and at too brief intervals. In these cases the most careful examination fails to find any morbid condition of the uterus, or any tendency to the so-called hemorrhagic diathesis. Yet there is a profuse flux from the uterus in these cases. Pain in one or other ovary there is, usually in the left; just as varicocele is more common in the male on the left than on the right side. This ovarian pain extends upward to the renal region: in this it differs from pain in the broad ligaments, which goes through the sciatic notch and extends down the thigh, both back and front of the affected side, and which does not go upward at all. There is also with this ovarian pain intercostal neuralgia, the inframammary pain so much complained of by women. There is commonly in these cases an excessive secretion of urine, the hysterical urine so-called; and in some cases there is the *globus hystericus*. When, then, a case of menorrhagia presenting the above features presents itself, and no fibroid, or polypus, or other uterine trouble can be made out, how must the practitioner proceed to treat the case? The first idea, Dr. Meadows says, in the mind of the practitioner, in ninety-nine out of every hundred cases of menorrhagia, is to think what astringent shall be used. Usually an astringent chalybeate is selected. But in these cases the persalts of iron are "worse than useless." Really they begin at the wrong end of the pole—at the uterine end and not the primary ovarian end. The drug of all others to be used in these cases is the bromide of potassium. He does not elaborate out the action of this agent (though its mode of action is now pretty well understood), but confines himself to the bare statement of its utility. Then as a local application he thinks conium to have the most effect as an anodyne. He uses it in a one grain dose in a pessary. Next to

this he prefers atropia as a local application. In such case he uses the alkaloid in preference to the galenical preparations—so that it should stand one grain of conia in each pessary.

Dr. Meadows said that this was but a fragment of a great subject, and he merely put forward his paper to suggest thought in other practitioners. As a matter of fact how much palpitation, and how much dyspepsia are due to far-away ovarian irritation, is only known to those who have learnt to recognize the relation. Dyspepsia with a clean tongue, my dear Yandell, whether accompanied by menorrhagia or leucorrhea, or both, with intercostal or facial neuralgia, you may take my word for it, is never, or hardly ever, primary; it is reflex, and ovarian in origin. *Experte credo!* Through how much blundering, how much ineffectual treatment and chagrin I have learned to know this, is confined to my own breast.

Sir Henry Thompson has recently published a series of cases of lithotripsy, performed completely at one sitting. For some years past he has been in the habit of removing small stones—those weighing less than eighty or ninety grains—at one sitting. He uses a very powerful instrument for the first crush or two, with a peculiar beak. "The difference in this new lithotrite consists in making the lower part of the male blade keel-shaped, or like the prow of a ship, while the upper part is still flattened; so that the instrument may execute powerful cutting and crushing actions simultaneously. The male blade is also placed at right angles with the shaft, and thus acts at a great advantage in comparison with a blade diagonally placed. At the same time the female blade retains its curve, enabling the instrument to be introduced with as much facility as heretofore. Lastly I have thickened the sides of the latter, and enlarged the opening to admit the prow of the male blade to enter it and drive out any *débris* which—with the increased amount of work now required—might otherwise lodge and impact the blades." Thirteen cases he then relates. "In all the cases appended I have used my improved aspirator, which I have described in the *Lancet*, February 1, 1879; and have removed large quantities of *débris* by it, and a smaller quantity by means of the flat-bladed lithotrites." He says one hard uric acid calculus weighed no less than three hundred and twenty-nine grains.

He continues:—"I have no hesitation in stating we owe to Prof. Bigelow the assurance that so much manipulation is tolerated by the

bladder in the process of removing the stone, provided we take it away or nearly so. It is quite true that the presence of sharp broken fragments in that viscus does more damage to it than the prolonged, but of course careful use of instruments for their removal. My former partial but not complete recognition of this fact for years past, led me to observe the value of a prompt and free use of the lithotrite and of Clover's aspirator when inflammation of the bladder has been produced by fragments; a fact to which I called especial attention on repeated occasions. Under such circumstances I have, with these instruments, removed from one hundred to one hundred and fifty grains at once, and thus instantly checked a violent cystitis. It is unquestionably better, however, to prevent than to cure; and this lesson, I think, is one which may be deduced from the foregoing cases."

He concludes:—"There is one observation I may make, and it is this. When the great bulk of a calculus of considerable size has been removed, say in fifteen or twenty-five minutes or thereabouts, and it is quite obvious that a small piece or two only remain, I would advise that, if another effort or two to remove these last be unsuccessful, it is better not to repeat fruitless manipulations, but to give over the search to a future attempt. As far as my brief experience above given enables me to judge, it is wise I think to leave, as I did in three or four cases, a fragment or two which seemed unwilling to be caught until a day or two later, and meantime had clearly done no harm. Lastly, there is a fact about which I have no manner of doubt, namely, that large and clumsy lithotrites are unnecessary for our purpose; and that the instruments I have described above are more efficient, safe, and speedy in their action than the large and unwieldy lithotrites which have been proposed."

And now, Vandell, I am off to the country for "a change of air and scenery." By the way, I heard a story about a corpulent friend of yours the other day. He was visiting a patient in a ward at the top of one of the pavilions of St. Thomas's Hospital. He is a punctual man, but was a few minutes late. The explanation was that he had essayed the lift—elevator you call it—which had given the job up half way, and he had been stuck. He was too much for *that* lift.

## Reviews.

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**Neurological Contributions.** By WILLIAM A. HAMMOND, M. D., Professor of Diseases of the Mind and Nervous System in the Medical Department of the University of the City of New York. Assisted by WILLIAM J. MORTON, M. D., of the University of the City of New York. New York: G. P. Putnam's Sons.

This appears to be No. 1 of Vol. I of a *quasi* periodical, to be issued by the publishers quarterly, or at least four numbers are promised for this calendar year,—all the contents to be written by the gentlemen named in the title.

The first paper in the present number is the "Non-Asylum Treatment of the Insane," by Dr. Hammond, purporting to have been read by invitation before the Medical Society of the State of New York in February, 1879, except so many of the foot-notes as are included in brackets.

At this distance it looks a little as if the memoir may have been published as a means of carrying the bracketed foot-notes to the public, they being, for the most part, an assault on the professional character of certain public officers—superintendents of insane asylums—against whom the author appears to have a private enmity. Notwithstanding this apparent animus of the paper, there are some good points in it regarding the nature of insanity and the best methods of managing its victims; but even these good points are clouded and robbed of a measure of their value by a strain of egotism that runs through the entire essay, and a fashion the author has of magnifying the importance of facts that support his purposes and obscuring those that militate against his aims.

Certainly the time has come for qualified men to discuss the propriety of building palaces—extensive, expensive and ornate—into each of which are crowded hundreds of human

beings robbed of their reason to a lesser or greater extent. The interiors of these palaces are arranged in the supposed interest and safety of the patients, but they are prisons after all, with some effort to provide facilities for a limited classification of prisoners. The exteriors of these palaces, with their imposing façades and a frontage of wings running to a vanishing point with artistic effect. These surely are not conceived and completed solely in the interest of the insane; they are for effect on the sane world, and are begotten in pride and perfected in vanity, and this presents broadly and squarely the question whether a pure christianity, a refined civilization, or a scientific technics, will support the view that underlies the indulgence of pride and vanity in connection with the management of the insane? There is a growing conviction with those fitted to judge in the premises, that less expensive and showy buildings, and more of them, will authorize a classification and a treatment of lunatics more in accord with advancing knowledge of both the physiology and pathology of the brain, and the attendant and dependent psychology.

The second paper is a clinical lecture descriptive of three imbecile dwarfs born of the same parents—who had also six other children normal in body and mind—and an analysis of their respective mental conditions. The lecture is by Dr. Hammond, and is illustrated by photographs of the dwarfs.

Another lecture by the same author is on what he names Mysophobia, which is defined to be "a morbid, overpowering fear of defilement or contamination." Dr. H. claims that this is a different species of insanity from *la folie du doute* of M. Le Grand du Salle; but at farthest they can be but varieties, and probably would not be given separate names but for the *penchant* for originality in the author.

Eight cases from the "Records of Practice" of Drs. H. and M. present various forms of nervous derangement and a very successful management; but such reported success does not necessarily imply that the cases were on that account selected.

Under the head of "Contemporary Literature," is given a petition to the New York legislature, charging incompetency

in the officers of lunatic asylums in that state, and mismanagement of these institutions, and suggesting a method of ferreting out the extent and nature of these shortcomings. Following this is a report of a committee of the Ohio legislature on the cruelties practiced on patients in Longview Asylum, near Cincinnati; and then this branch of the literature closes with an extract from the report of Dr. Morse, superintendent of the asylum at Dayton, Ohio, warmly commending the views and practice of Dr. Morse.

One is impressed by a certain air that seems to pervade these articles about hospitals for lunatics, that they have been gotten up and published under an inspiration not wholly derived from a pure and philanthropic desire to improve the sanitary estate of the insane under state care, but that defects in this department of state policy have been seized upon and made the pretext for an assault, by indirection, upon professional gentlemen whose lives and actions have not been squared by the rule presented by the author of this publication. The first and last articles, therefore, in *Neurological Contributions* appear to have been born of the same spirit.

J. F. H.

**The Pharmacopœia of the Hospital for Diseases of the Skin, London.**

Edited by BALMANNO SQUIRE, M. B., London, Senior Surgeon to the Hospital. London: J. and A. Churchill.

This book contains the formulæ for two or three hundred preparations of ordinary medicines in the manner adopted by the London Hospital for Skin Diseases, and in every case the purpose for which the preparation is applied is briefly mentioned. Perhaps it would be as well to call these formulæ prescriptions, as they do not embrace any of the preparations of the British Pharmacopœia specially named for diseases of the skin. The information in this little book might be useful to sundry professional persons, and valuably suggestive to many.

J. F. H.



**Diseases of the Throat and Nasal Passages**—A Guide to the Diagnosis and Treatment of Affections of the Pharynx, Esophagus, Trachea, Larynx, and Nares. By J. SOLIS COHEN, M. D., Lecturer on Laryngoscopy and Diseases of the Throat and Chest in Jefferson Medical College, Philadelphia. Second edition, revised and amended, with two hundred and eight illustrations. New York: William Wood and Co. 1879. 742 pp.

A second edition of Dr. Cohen's treatise has been promised for some years, but has been delayed by causes beyond the author's control, as he informs in the preface. The present edition has one hundred and sixty pages more than the first, and seventy-five more illustrations. One hundred and sixty pages do not cover the entire increase of text, because several pages of bibliography, as well as some other matter, have been omitted from this edition, and their places supplied with fresh material derived from the author's increased experience and the general advancing knowledge in this department of medicine. "The author's Lectures on the Surgery of the Larynx, Nares and Trachea, delivered before the College of Physicians, Philadelphia (1872), and those on Fetid Coryza (1873), on Sore Throat, and on Diphtheria (1874), before the classes in Jefferson Medical College, and published respectively in the Philadelphia Medical Times, Philadelphia Medical and Surgical Reporter, and New York Medical Record, have been substantially incorporated into the present edition."

This renders the book before us a very complete treatise on diseases of the throat and nares, strongly tinged with the author's individuality; but a book is all the better for its author's individuality, provided it be the individuality of integrity, intelligence and experience, and such is Dr. Cohen's. While, however, the author draws chiefly from his own resources of clinical knowledge, his observation and experience have been made and obtained on a thorough examination and appreciation of the teachings of other worthy investigators of the same classes of disease, to whose writings he makes sufficient reference.

The book is divided into seventeen chapters, covering a description, with pictures, of the various instruments used, and

instructions, with illustrations, for handling them; descriptions of general and special diseases of the throat and nares, with practical clinical illustrations of both symptoms and treatment. One chapter is devoted to diphtheria, and in other chapters the author treats of croup, scarlatina, mumps, and other systemic ailments not usually classed as throat or nasal diseases. He takes some pains to point out the differential diagnosis between diphtheria and croup—a difference that some good doctors do not see, though they ought to; and his treatment of membranous croup is less heroic and more rational than our text-books usually inculcate, but might be still further modified in the same direction with advantage.

The volume will accordingly be found to embrace the latest and fullest exposition of the nature and treatment of all diseases manifesting themselves in disorder of the throat and nares, whether systemic, local or neoplastic.

The type is large, on thick soft tinted paper, and the woodcuts for the most part are excellent.

J. F. H.

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**A Guide to Therapeutics and Materia Medica.** By ROBERT FARQUHARSON, M. D., Edin., F. R. C. P. Lond., Lecturer on Materia Medica at St. Mary's Hospital Medical School, etc. Second American edition, revised by the Author. Enlarged and adapted to the United States Pharmacopœia by FRANK WOODBURY, M. D., Physician to the German Hospital, Philadelphia. Philadelphia: Henry C. Lea.

“There is no more encouraging evidence of progress in medical science than the growing desire of the profession for exact information concerning the action of remedial agents.” This is the opening sentence of the American editor's preface, and it is true; but one may add that the longed-for goal is apparently yet afar off. Therapeutics has more serious impediments to overcome in its progress toward the complete than any other department of medical science. The force and direction of the action on the human system of a number of drugs are so well established that this certainty is made to

serve as the basis of a series of assumptions in regard to the action of a large number of drugs whose influence has never been demonstrated. Frequently nothing is known of the influence of a drug on the system in a physiological condition that is asserted to have the most valuable influence on the system in a pathological condition. Dr. Farquharson has sought to secure something of precision in this behalf, so far as present knowledge is available to that end, by placing the physiological action of medicines and their therapeutic application in parallel columns on the same page. This is undoubtedly of value, and would be of immeasurable service if it were not for the fact that exact knowledge of the action of medicines on man in a physiological condition is too limited to be relied on in any considerable number of remedial agents; and, furthermore, it must not be forgotten that drugs do not always have the same action on man in a pathological state that they do in his physiological state.

This book has an introduction of forty-three pages, discussing the routes by which medicines enter the system, the general rules for prescribing, dosage, and the comprehensive principles of therapeutics. Then thirty-six pages of remarks on remedies by classes; then three hundred and thirty-six pages, devoted to the delineation of the physiological action and therapeutic value—but not to their history or preparation—of individual medicines, official in the United States Pharmacopœia; then thirty-two pages descriptive of the importance and value of medicines, not official in the Pharmacopœia—and this includes some of the most powerful and valuable remedial agents now in the service of practitioners. Then six pages about poisons, their antidotes, and the treatment of their effects. Then seven pages of questions—numbering seventy-two—intended for exercise for students and others, and to test their ability to answer off-hand each to himself, many important queries that arise in the every-day prescribing of medicines, and which it would be best all could answer without recurrence to authority, but some of which it is feared would puzzle some practitioners a score of years in

the service. And then the reading matter closes with five pages of elucidation of the metric system; and, by the way, all prescriptions in the book are written in metric quantities, as well as in the old style. A full double index—eighteen pages of diseases and their remedies, and twenty-two pages of general index—closes the volume.

The first edition of this work was issued in 1877, and exhibited evidence of haste and carelessness in preparation, which was noticed by the reviewers. In the preface to the present edition the author returns thanks to his critics, says he has profited by their labors, and expresses the hope that they will treat this edition as they did the first. There is not in this issue the same foundation for objection in this behalf that there was in the first, but the book is not yet entirely free from such defects.

The book is a compendious and instructive guide to therapeutics and materia medica, intended for the student and young practitioner, but may be valuable to practitioners of any age; and if carefully studied might add something toward a barrier against the use of the immeasurable trash of countless names with which manufacturing pharmacutists are flooding the country, themselves declaring the medicinal virtues of their wares, or having them extolled by the hired experience of witless doctors.

J. F. H.

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**Handbook of Diagnosis and Treatment of Diseases of the Throat and Nasal Cavities.** By CARL SEILER, M. D., Lecturer on Laryngoscopy at the University of Pennsylvania, etc. With thirty-five Illustrations. Philadelphia: Henry C. Lea. 1879.

As a brief, clear exposition of the armamentaria of the laryngologist and rhinologist, and of the symptoms and treatment of diseases of the throat and nasal cavities, Dr. Seiler's little book is a success. All theoretical discussion is avoided, but a plain, concise statement of the symptoms, subjective and objective, of the various disorders of these parts is given;

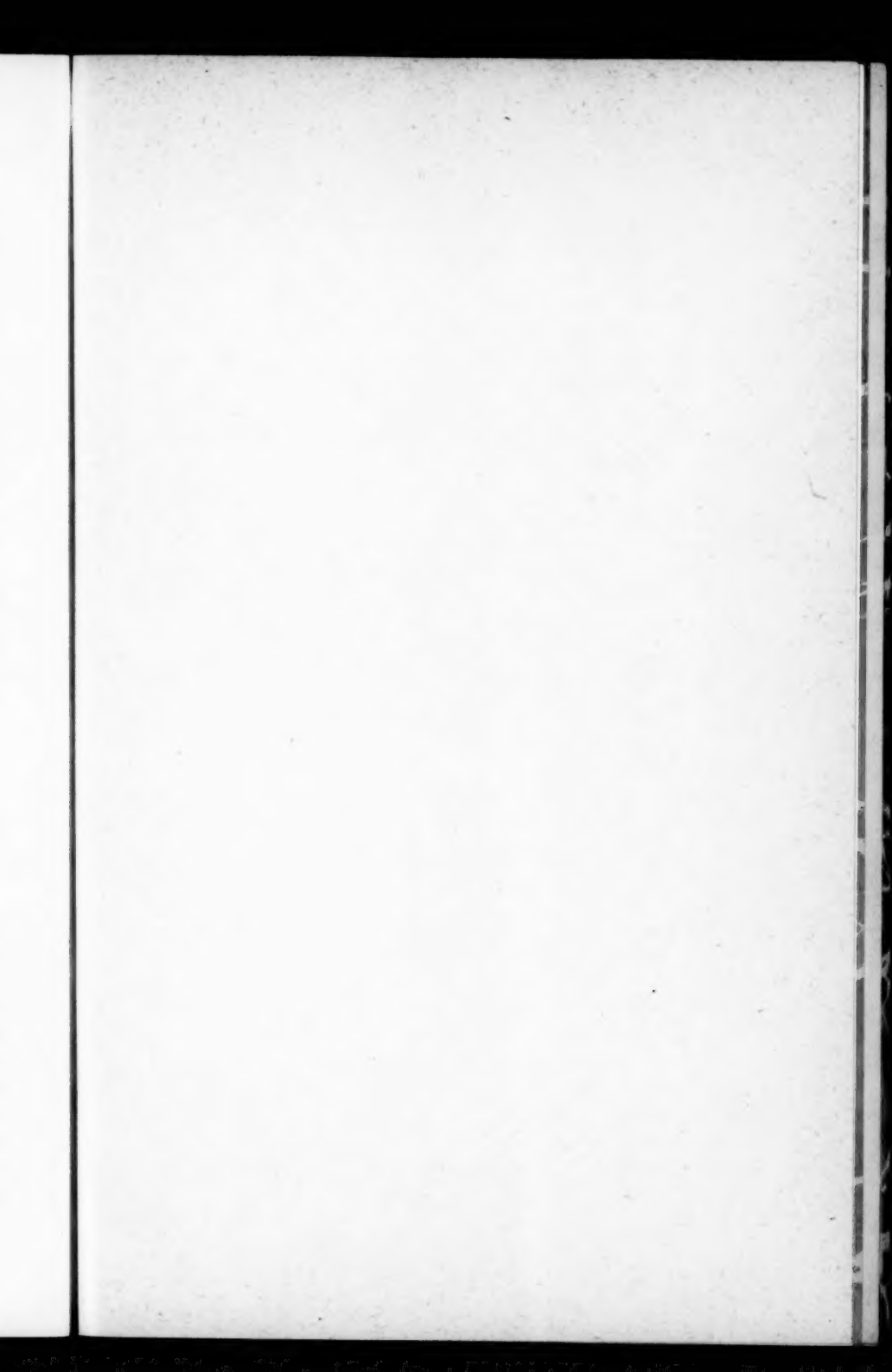
and with equal directness and precision the author's views of treatment are presented, inclusive of all essential details, and directing how to avoid accidents, errors and mistakes in the delicate operations required. One can not but be gratified at the pains he takes to instruct as to the value and method of applying the nasal douche, pointing out the mischief that is often done by its wrong manipulation, and the improper character of the fluids used. This advice is needed, for it is probable that the injudicious use of this *quasi* popular instrument has accomplished enough mischief to more than counterbalance the good it has done. Dr. Seiler details a treatment that he tells us will cure "hay cold," as he names hay fever; and what is better, informs us how it may be prevented.

The confident tone of the book will suit the young doctor, who does not like *hems* and *haws* nor *ifs* and *buts*; and if older practitioners find fault, it will be with too strong a manifestation of faith in drugs, and that the implied constant success of treatment can not be realized in practice. J. F. H.

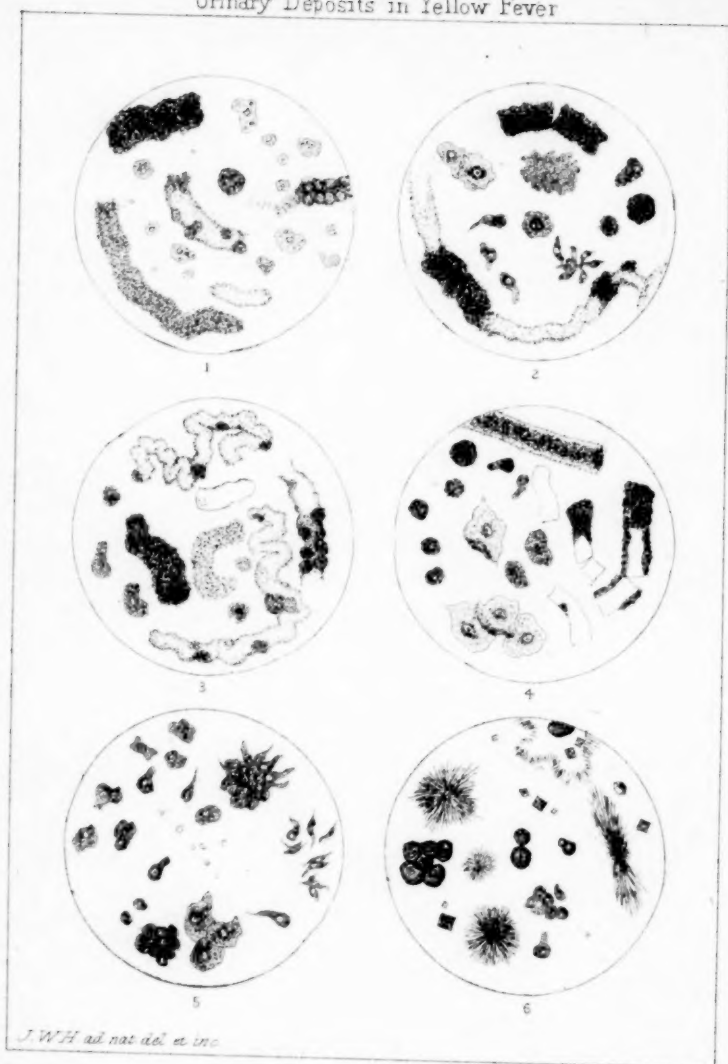
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**Posological Table**—Including all the Official and the most frequently employed Unofficial Preparations. By CHARLES RICE, Chemist, Department of Public Charities and Correction, New York. Revised and approved by members of the Medical Boards of Bellevue and Charity Hospitals. New York: William Wood and Co. 1879.

By means of intelligible signs and abbreviations the author has managed to place into this little book nearly two thousand names of medicines, simples and preparations, official and unofficial, in the United States Pharmacopœia, their composition and average dose for the adult. After the dose of all active or poisonous medicines, symbols indicate the necessity of caution in increasing the dose, and to some extent signify the limit of safety. For the purpose intended it is a well conceived and executed work, and may be kept for reference or as a remembrancer, with advantage, by those who need such aids outside of the regular text-books and systematic treatises.



# Urinary Deposits in Yellow Fever



*J. W. H. ad nat. del. a. inc.*

- 2 Type of Sediment after 4<sup>th</sup> day in malignant cases.
- 1, 3 & 4 Variations from the type after 4<sup>th</sup> day.
- 5 Type of Sediment after 2<sup>nd</sup> day in mild and up to 4<sup>th</sup> day in severe cases.
- 6 Leucine and Tyrosine, occasional 3<sup>rd</sup> day.



## **Clinic of the Month.**

THE URINE IN YELLOW FEVER—A CLINICAL STUDY.—The following article upon a subject in which we are all interested, by Prof. J. W. Holland, M. D., of Louisville, we extract from the *London Practitioner*, July, 1879. Dr. Holland has sent us some conclusions, which are appended to the article:

It is the opinion of many besides Dr. A. Flint that "further study of the urine in yellow fever by means of chemical and microscopical examination is a desideratum." Ballot, Blair, and Lawson, have asserted that the least doubtful sign of it is derived from an examination of the urine. These considerations moved me to direct particular attention to this excretion by the usual methods of clinical analysis, when the opportunity was afforded in the outbreak at Louisville, Kentucky, during September and October, 1878. Drawings of the sediments and brief records were made in the study of twenty-five cases occurring in the infected district and presenting symptoms more or less suspicious. Nearly all of these would have been grouped in the family of fevers called yellow had they appeared in a region where the disease was expected, or where it had ever held undisputed sway. Inasmuch as this was the first time indigenous yellow fever had appeared in Louisville, and its identity was considered by some not indubitable, the specific name is applied to fourteen out of the twenty-five, these being of the malignant grade and such as are everywhere recognized as the disease in question when it appears in the epidemic form. The epidemic slowly widened its boundaries, and ceased only with the appearance of a hard frost.

These cases were all in near local relation with the dépôt of the Louisville and Northern and Great Southern Railways,

and constituted about half of the entire number that made up the outbreak. They presented these symptoms in common: ushered in by a chill; there were headache, backache, and soreness of the limbs, followed by a fever ranging in temperature from  $102^{\circ}$  F. to  $105^{\circ}$  F.; the epigastrium was tender or painful, and stomach irritable; color of the skin at some time bright yellow; excessive vomiting, sooner or later black vomit appearing. The urine was scanty or suppressed and albuminous.

In most of them the eyes were congested and ferrety; the odor of the person slightly nauseous and ammoniacal. There were no regular remissions of the fever, which was in some cases variable until death, in others there was an apyrexia on the fourth day; and in all, though the temperature was elevated, after the reactive stage the pulse was peculiarly slow and compressible.

The early cases having been cinchonized without benefit, the later ones were not so treated; all but two of these severe cases were fatal between the fourth and the seventh day.

Some of them I saw in consultation with Dr. Cox, for the reports of others I am indebted to Drs. D. W. Yandell, Cox, Scott, Manly, and Palmer. The accompanying plate gives a faithful reproduction of the characteristic objects as seen with a power of two hundred diameters.

FIG. 1 represents the deposit from the urine of a white boy, S—, aged fourteen. It was passed through the catheter, after deep pressure above the pubis, on the fourth day; death occurred in delirium on the fifth. It contained diffused granular matter and renal tube casts, highly, moderately and slightly granular. Some have epithelium embedded, and in various parts of the field are single fat cells from the urinary passages, which are studded with small flat globules. He had complained of malaise and frequent urination for several weeks. This may account for the fatty degeneration which was presented in one other subject who had been "on a beer spree" for a week before the initial symptoms. The urine was acid, lemon yellow, bile pigment, and one-half albuminous.

FIG. 2. This is the appearance of a copious brownish deposit from S. J——, white male, aged thirty-five, passed freely on the fourth day of fever. Death, preceded by hemorrhages from various parts, ensued three days later at the Yellow Fever Hospital, to which in the meantime he had been conveyed. It was pronounced by the physician in charge as marked a case in every detail as any that had been received as refugees from Memphis, Tennessee. The objects seen are: at the top a highly granular tube cast, made probably of degenerated renal epithelium; such cylinders abound, though all have not a sharp fracture and squared ends. At the bottom is a cast of a convoluted tube, in one part large enough to show that it was probably made of the disorganized cellular lining, and diminishing in size to the caliber of the tube when intact. These interesting forms were quite common in the grave cases. The clear portion is probably the mucoid matter of Beale. In the middle of the field is a patch of tessellated epithelium from the bladder, and some scattered cells with strongly-marked nuclei. There is a group of spindle-shaped cells, probably from the pelvis of the kidney. On the right is the "compound granule corpuscle," found in the other cases also wherever the granular cast was to be seen.

This figure is a type of the deposit seen on and after the fourth day in the following cases: M——, aged forty-eight, white male; V——, aged two and a half, white male; G——, aged thirty, white male; G——, aged twenty-six, white female; mulatto boy, aged twelve; McN——, aged thirty, white male; C——, aged forty-five, white male; C——, aged eighteen, white male; L——, aged twenty-five, white female; M——, aged thirty-two, white male—all of whom died. Only one case presenting these with the other grave signs survived. This was a negro boy, P——, aged eighteen, whose urine was of dark red color from hematine, almost solid when the albumen was coagulated, and in which was found bile pigment. This, the only case of hematuria, recovered, and is to-day in fine health, which goes a little way to confirm the observation of Dr. Blair, that bloody urine was a favorable indication.

FIG. 3. The deposit from a specimen voided without difficulty on the eleventh day after the primary chill, by F—, aged forty-five, white male, of robust frame, who slowly regained and now retains his wonted health. He resides at Tenth and Dumesnil streets, a neighborhood that furnished no other cases to this report, at least half a mile from the infected district. His occupation, as watchman in the freight depôt of the Louisville and Northern and Great Southern Railways, brought him in the early morning within the range of a locality that proved so fatal to many. I saw him on the twelfth day in consultation with Dr. John E. Crowe; he then exhibited some restlessness, slight suffusion, and yellowness of the eyes; temperature normal, but pulse sixty-six and rather feeble; appetite and digestion good.

He had been seized with violent headache and pains in his limbs; then there was a chill and febrile movement that lasted about two days. His temperature was normal after the reaction, but his pulse compressible and sometimes only sixty to the minute. In the beginning his eyes were so red that his wife concluded he had caught cold in them.

Early in the attack his epigastrium became tender and his stomach very irritable; for several days he continued vomiting bile, but no blood. Toward the close of the first week hemorrhage from the gums set in, and, despite treatment, lasted nearly one week. He was cinchonized early. His urine was not examined until the eleventh day, when it was found acid, deep-red yellow, specific gravity 1.024, quantity normal, and one-fourth albuminous. Bile pigment was present, and a heavy lateritious deposit fell. Under the microscope amorphous urates were so abundant as to obscure other objects; gentle heat cleared them away, and there was revealed the field seen in Fig. 3: tube casts, granular, epithelial, and hyaline, with renal and vesical epithelium stained yellow. The worm-like mucoid casts were of a faint yellow tinge, or they would have been difficult to detect. I am inclined to call this yellow fever of a variety different only in degree from the unquestionable type before adopted as a safe basis of classifi-

cation. It is a significant fact that M., above named as dying from the typical form, was a night clerk in the same depôt with the last described person. Both resided in parts widely separated from the depôt, and had nothing in common but employment there during the night or early morning.

FIG. 4. Objects seen in a dense deposit from the urine of Mrs. V——, aged thirty, pregnant at the fifth month. It was voided on the fourth day after seizure; she died three days later. The urine was acid, scanty, bright yellow, and one-third albuminous. Besides epithelium from the vagina, urinary passages, and kidney, there can be seen small waxy casts with a sharp fracture, some embedded in granular matter, and one containing granular matter in its axis. This was the only case which showed the waxy cast unmistakably. All the objects were stained yellow.

FIG. 5 is the appearance of the field on the third day in several cases examined at that time before the appearance of albuminuria. The objects are squamous, round and transitional epithelium from the bladder, and spindle-shaped cells probably from pelvis of kidney. Sometimes they were found in patches that covered half of the entire field. They were found sparingly in some cases of a mild form in which albuminuria was at no time present.

FIG. 6. Deposited from the urine of McK——, aged forty-five, who lived in the center of the infected district, and whose history, as obtained from Dr. Crowe, is as follows:—He was attacked October 10th with chill and headache, the temperature rose to 104°, and soon fell to 99° F. The general run of his pulse was sixty to the minute; his stomach was irritable, vomiting bile. His skin was yellow and flushed. He was cinchonized, and became convalescent by October 22. He was well before the seizure, and it left no sequel.

The urine of the fourth day was alkaline, yellow from bile pigment, not albuminous, and gave a light deposit, with the following microscopic characters as seen in the figure: bladder epithelium singly and in patches; groups of leucine spheres of a yellow color, and well-defined outline with concentric mark-

ings, shown on the left and in the center; tyrosine needles in stars and sheafs, with abundant octohedra of calcium oxalate. The specimen from which the drawing was made was mounted with a ring of cement after keeping it a few days under cover without change, and is now in my cabinet as perfect as it was six months ago. The cells and other organic matters owe their preservation to the biliary principles. Granting that the epidemic was one of yellow fever, as shown by the previously cited cases, the collateral evidence makes the conclusion inevitable that this last one occurring at the same time and in their midst is the ephemeral or mild form of the same disease. Leucine was recognized in imperfect forms where the urine had dried on the glass, in some other cases when biliary matter was abundant. Here it and its congener tyrosine are present beyond question.

When this paper was presented to the Kentucky State Medical Society in April last, in order to adapt it to the needs of the occasion the detail above given was not read, but instead the following conclusions were offered:

Attention is drawn to the following points:

1. That the desquamative process from the urinary passages, considered by Lawson as distinguishing yellow fever from pure intermittent and remittent, was present in every specimen described.
2. That in further agreement with his observations, where there was black vomit or some analogous discharge of blood, there was also the peculiar urinary symptom.
3. That the granular tube casts, like the black vomit, must be regarded as a grave portent; out of thirteen white subjects showing them, twelve died.
4. That the implication of the liver is denoted not only by the bile pigment, but sometimes by leucine and tyrosine in the urine. To reveal their presence, manipulations favoring slow evaporation are required.

The coëxistence of albumen with biliary principles in the urine would lead one to look for leucine and tyrosine; yet in

a somewhat extensive search through the literature of the subject, I have failed to find their presence in yellow fever urine noted by any previous observer. They have been found in rapidly destructive diseases of the liver, such as acute yellow atrophy, and occasionally in typhus and typhoid fevers, and in small pox; consequently their existence in yellow fever urine is not diagnostic. They denote serious derangement of the liver.

TWO CASES ILLUSTRATIVE OF TWO IMPORTANT POINTS IN ELECTRO-THERAPEUTICS.—These cases are neither novel nor unusually interesting, so far as the symptoms of disease alone are concerned. I present them because they illustrate two very important points in therapeutics, especially electro-therapeutics, namely, the necessity for, and the good results that come from, perseverance in seemingly hopeless cases of infantile paralysis, and furnish a suggestion in regard to the differential indications for the use of galvanism and faradism in the relief of pain.

CASE I. I call attention first to this little boy, aged four, sent to me by Dr. S. H. McIlroy, of this city.

In September, 1877, the patient suffered from a very severe attack of chills and fever, followed by convulsive seizures. One week subsequently the right leg was found to be completely paralyzed, the other limbs, with the exception of the left arm, being also affected, but in a less degree. In March, 1878, six months later, the case came under my care. The leg was apparently without life, quite cold, and atrophied to the last degree, while the electro-muscular contractility was completely abolished, and probably had been for some time. After a month's treatment by general faradization and localized galvanization, the general condition had somewhat improved, but there was not the slightest evidence of returning galvanomuscular contractility. In two weeks more, contractions, almost imperceptible, were observed. These increased very slowly, and it was six months before the muscles responded in the least degree to faradization. At the present time, after



a year of the most persistent endeavor, the contractions are considerable, the limb has increased much in size, its circulation is good, and the child can, with the aid of a chair, move about quite readily. I conceive it to be self-evident that if this patient had not been treated with unusual persistency, or if active measures had been delayed much longer, a condition of life-long helplessness would have followed. In consideration of the absolute and long-continued paralysis and loss of electric response to either current, the results have impressed me deeply, and should teach that even desperate cases of infantile paralysis should not be hastily abandoned to their fate.

CASE II. The second case, Mr. C., aged forty, was sent to me by Dr. Malcolm McLean, of this city, with the following history: Last Christmas, without knowledge of special exposure, but subsequent to much mental depression, the patient began to suffer from extreme pain in the lower part of the back and in the hip. A week later, the pain extended down the leg to the ankle, along the course of the sciatic nerve. The pain, instead of being sharp and shooting, was of a dull, aching character, and though at all times severe, yet frequent exacerbations occurred, rendering him quite helpless. After various methods of treatment, he attended a clinique at the College of Physicians and Surgeons, and submitted to cauterization of the limb, but with no good results. When I saw the patient, two weeks since, he had been suffering six months with no relief, and latterly the symptoms had increased in severity. On examination I found that firm and prolonged pressure did not increase the pain, but afforded rather decided relief. On the contrary, slight pressure caused all along the posterior aspect of the thigh very intense pain. I was well aware of the probable indications for treatment, but in order to test the case thoroughly I made a careful labile application of the galvanic current, with no good effect certainly, but rather with some increase of pain. Two days subsequently I resorted to faradization, placing both feet of the patient, that belonging to the sound as well as to the diseased leg, on the

negative pole, and using an exceedingly fine current, avoiding all motor points, and carefully refraining from producing appreciable muscular contractions. The patient has been thus treated but three times, and is, as you observe, nearly well.

The points of this case that I wish particularly to emphasize are these:—First, that in differentiating between the use of the two currents for the relief of pain, the effects of pressure are most useful guides. Second, that while true neuralgia, as defined by Anstie, and pain generally yields as a rule more readily to the galvanic than to the faradic current, the latter is in some cases not only invaluable, but relieves where galvanism is worse than useless, since it serves only to exaggerate the existing distress. Hysterical neuralgias and the so-called pseudo neuralgias, which are simply forms of pain, occupying certain areas, and running seemingly in the direction of certain nerves, undoubtedly indicate the faradic current. In these cases it is well known that firm pressure tends to relieve, while light touches aggravate, the distress. This suggestion in regard to the effects of pressure in neuralgia as indicating the proper electrical treatment I have offered before, and have tested it very satisfactorily in many cases. While I do not enunciate it as an unvarying law, it will certainly be found exceedingly useful as a guiding symptom, and the above case of sciatica is, perhaps, as striking an example of its truth as any I have met with. (A. D. Rockwell, M. D., in *Boston Med. and Surg. Jour.*, August 21.)

A SIMPLE METHOD OF PREVENTING MAMMARY ABSCESS.—Dr. Francis J. Shepherd, in the *Canada Medical and Surgical Journal* for July, writes thus of this distressing affection:

There is, I suppose, no accident which brings more discredit or gives more trouble to the surgeon than the occurrence in his practice of a "broken breast" case. Many remedies, such as belladonna, hot oil, frictions, etc., have been advocated to prevent this painful affection; but I have found none more efficacious and speedy than the following simple plan which has been used for years with great success by old women in

country parts: in fact it may well be called, what indeed it is, an "old wife's remedy." When the gland becomes indurated, painful, and has a glistening red look—symptoms, in fact, of approaching suppuration—take a large piece of ordinary sticking-plaster, and cut it a circular shape (a larger or smaller disk, according to the size of the affected breast); make a hole in the center large enough to allow the nipple and half the areola to be seen, and apply this piece of plaster (after heating it) so that it will cover the *whole* breast, and that the nipple will protrude through the aperture in the center. To make the plaster fit more accurately, its circumference should be deeply nicked at distances of about an inch. The plaster should be left on till the breast softens, or the plaster ceases to exercise even pressure. This simple method, in the half dozen cases I have seen it used, has acted magically, the breast softening and the pain disappearing in the course of twenty four hours. In one case a woman, who had suffered on several previous occasions from broken breasts, came to the out-door department of the General Hospital with all the symptoms of fast approaching suppuration in her right breast; in fact, I considered that within twenty-four hours I should be obliged to use the knife. However, I said to the students that if there was anything in the plaster remedy, this would be a good case in which to try it. I applied the plaster in the way described above. Two days after the woman returned and said, with a pleased smile, that it was the only remedy she had ever tried that had done her any good; that on previous occasions every remedy had failed to prevent her having a "broken breast." On examining the breast, I found it quite soft, painless, and with only one small lump of induration on the upper part, which disappeared in the course of a couple of days. In another case, where an abscess, due to depressed nipple, threatened, I applied the plaster as before, and in twenty-four hours there was hardly any induration, and no pain. In multiparæ, where the breast is dependent, in addition to covering the breast with plaster, I should advise supporting the breast by a band of plaster, an inch and a half

broad, passing under the breast from shoulder to shoulder. I may say that I have only used this remedy in cases of threatened abscess, due to distension of the milk ducts, depressed nipples, and obstruction to a free flow of milk, due to exposure to cold. I imagine the plaster acts simply by exercising an even pressure on the breast and giving support to it.

DIPSOMANIA AND DRUNKENNESS.—In the Transactions of the Medical and Chirurgical Faculty of Maryland (1879), is an article by I. D. Thomson, M. D., junior physician to the Mount Hope Retreat Insane Asylum, in which he makes a distinction between drunkenness as a disease (dipsomania), and drunkenness as a vice, and the different classes of people affected by the two forms. He says:—"The one form of drunkenness, then, is clearly a vice, whilst the other is just as certainly a disease, and yet the victims are none the less both drunkards; burdens to themselves, to their families, and to the communities in which they reside, and a crying reproach upon the enlightenment and the controlling powers of the age in which we live."

He continues:—"How is this great evil to be remedied? Without assuming to myself the legal qualifications to frame such a law as would at once work smoothly, to the accomplishment of the object in view, or without entering at this time into full particulars, I would yet recommend and urge the enactment of such state laws as should cause the judge of the criminal or circuit courts, upon his being notified by next of kin—or other proper persons—that any individual was a confirmed drunkard, and had committed any misdemeanor or breach of law, to appoint a commission of three competent men (at least two of whom should be respectable practicing physicians), qualified to distinguish and determine the character of the drunkenness to be found. And this commission should be required to thoroughly inquire into the history of the case, and also to examine the drunkard himself; and if such inquiry and examination—under certificate or affidavit of said commission—should determine the individual to belong

to the class of *ordinary drunkards*, then it should be the duty of said judge to commit the said ordinary drunkard to our House of Correction, for a period of from four to twelve months. But if, on the other hand, the finding of the said commission should determine such drunkard to be a *dipsomaniac*, then such dipsomaniac should, in like manner, be committed to a properly conducted inebriate asylum, for a period of from one to four years; and such asylum should be vested with full legal authority to carry out the system of compulsory detention and control. But if, as is now the case, no such properly conducted inebriate asylum existed in our state, then the said dipsomaniac should be committed to an insane asylum, whose managers should have the same authority to detain and control, as in other cases of insanity.

"And if, during the term for which such dipsomaniac had been committed—say after one year of treatment—the superintendent of such asylum should have good reason to believe that a cure had been effected, and in his judgment deem it advisable to test the question of cure, then said superintendent should have the authority to permit such patient to go at large temporarily, without restraint, on probation; his being returned to the asylum or not depending upon the ability of such patient to control his propensity for drink. Also, that inebriate asylums—or in their absence then insane asylums—should be vested with legal power to detain and control, for not less than one year, such dipsomaniacs, as in the earlier stages of this disease might voluntarily seek admission and treatment. And also, if at any time during the period for which such dipsomaniacs had been committed, the said court should receive creditable notification that such patient was unjustly detained in such asylum, then the said court should appoint a commission of three competent physicians, who should confer with the superintendent of such asylum, and should also visit and examine the said patient, alleged to be detained unjustly, and, upon the decision and report of such commission, the said court should issue an order either for the discharge or for the continued detention and treatment of such patient."

### Notes and Queries.

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"WE HAVE CHANGED ALL THAT."—Time was when famous philosophers, physicians and theologians fully believed and earnestly maintained the doctrine of final causes. Indeed only three years ago, one of the ablest of French philosophers\* published an elaborate volume in vindication of this doctrine. Less than a year ago an English translation of this work was issued in Edinburgh. In a preface written by the distinguished author for this translation, the following passages are found: "Great Britain has always been the classic land of final causes. It is there that natural theology originated, has been developed, and held its ground with honor down to our days. In our own age a great publicist and a great physiologist, Lord Brougham and Sir Charles Bell (both Scotchmen), counted it an honor to annotate the excellent work of Paley. Dugald Stewart, in his *Elements of the Philosophy of the Human Mind*, vindicated against Bacon the utility of final causes as a means of research, at least in the sphere of the natural sciences. What are called the *Bridgewater Treatises* have rendered popular, by a succession of scholarly studies, the argument drawn from design in nature; and recently, again, these remarkable works—the Duke of Argyll's *Reign of Law* and Prof. Flint's *Theism*—have anew called attention to this famous and indestructible argument."

Famous enough the argument is, but how foolish Janet seems to us pronouncing it indestructible in October, 1878, while in August, 1879, the editor of an American medical journal declares it wholly rejected. "We have changed all that," and the change has been very quickly and completely

effected, and the foolish superstition is at an end. The journal referred to states—"The logical necessity of assuming intelligent design in order to explain the adaptations of nature, is wholly rejected now even by many theologians."

Molière, in *Le Médecin Malgré Lui*, gave an example of another important change in the following:

*Géronte*.—"It is undoubtedly impossible to argue better. There is but one thing that I can not exactly make out: that is the whereabouts of the liver and the heart. It appears to me you place them differently from what they are; that the heart is on the left side, and the liver on the right."

*Sganarelle*.—"Yes; this was so formerly; but we have changed all that, and we now-a-days practice the medical art on an entirely new system."

*Gér.*—"I did not know that, and I pray you pardon my ignorance."

*Sgan.*—"There is no harm done; and you are not obliged to be as clever as we are."

Of course we can not all be "as clever as" some scientific men get to be. King James remarked in regard to Lord Bacon's great work, "*It is like the peace of God, for it surpasseth all understanding.*" And so of some of this cleverness. Dr. Cowling, in the Louisville Medical News, Aug. 16, has this to say of the criticism:

"There is no danger of any one lighting up a superstitious fire along the American line, and not having the same promptly squirted on from the cold waters of the Philadelphia Medical and Surgical Reporter. This faithful watchman upon the towers of medical Asrael of course is not pleased with the President's address before the last meeting of the Association; that is, in so far as it attempts to prove any thing. 'The logical necessity of assuming intelligent design in order to explain the adaptations of nature is wholly rejected now even by many theologians,' says the P. M. and S. R. Why it should feel called on to assert this self-evident truth we do not see. All the world knows by this time that it was manufactured by Mr. Tyndall, with the help of a select company of American apprentices."



CORPORAL PUNISHMENT.—B. P. Marsh, A. M., M. D., Bloomington, Ill., has sent us the following, and requests that it be generally published by other journals:

"My attention has for a number of years been called to injuries caused by occasional cases of too severe or recklessly executed punishment of school children.

"Foremost educators, while not believing it expedient to prohibit corporal punishment, acknowledge that injury, injustice, and sometimes death even, do now and then occur from its use. These serious results may arise from fright or from concussion of the brain, produced by merely jerking the child about, or—the most frequent case—inflicting the punishment upon the child's head. No one form of punishment is so dangerous as boxing the child upon the ear. Not only is injury to the organ of hearing produced, but inflammation of the brain frequently follows, and death has been the result. In the family, this matter of injurious methods of punishment is not by any means beyond our influence, if we will but take pains to inform people upon the subject. If corporal punishment is allowed at all in schools, its use ought to be carefully guarded. No teacher should be allowed to punish a child by rudely jerking it about, by striking it anywhere on the head, or with any instrument whatever, except it be flexible and with smooth edges. These requisites are best fulfilled by a rubber strap with rounded edge. Moreover no punishment should be permitted except it be inflicted in the presence of a principal, another teacher, or a school trustee, as a salutary check upon undue temper or excitement. Every case of corporal punishment should also be reported in writing to the board of school trustees, stating the offense of the pupil and the manner and severity of the punishment. I have known the above rules, adopted by a board of school commissioners, to reduce the number of cases eighty eight per cent. in one month, and the schools continued meanwhile even more orderly and satisfactory than before.

"I am about collecting statistics of serious and fatal injuries caused by corporal punishment, and I write this article to

request all the readers of the *American Practitioner* to forward to me statistics and history of all cases that may have come to their knowledge. State the date, place, name of child, character of punishment and its results, also the offense for which the punishment was inflicted. Add other points, history, etc., if time and inclination suggest. I urge all to give the subject the little attention needed,—to write me the main facts at least of all cases they have known, and thereby make the report more valuable. The information thus obtained I will communicate through this journal."

DEATH OF DR. M. B. WRIGHT.—Dr. M. B. Wright died in Cincinnati on August 15th. This man of iron will, and apparently of iron constitution, who seemed to stand on his feet firm as a statue, then too with something of a statue's fixed proportion and with something of a statue's rigid lines in his face, has fallen. He had lived for nearly seventy-six years, yet many at fifty-five or sixty look older than he did.

For five years an associate in the Medical College of Ohio, and during the ten years that have elapsed since that association, holding frequent correspondence with Dr. Wright, there grew up between him and the writer a precious friendship now rudely and suddenly arrested. These letters were, on his part at least, delightful manifestations of kindly personal interest, sometimes genial gossip of men and things, and again graver thoughts on professional subjects, or on the profounder problems of human life. His last letter to me was written on the 31st of July. In it, in connection with the subject of evil in the world, he wrote as follows:

"I have asked what have I done or left undone, that I should be thus punished. Is this a part of an original direct design, or is it a consequence of my own thoughtless creation? No one assumes to answer. After all, perhaps, I should not complain. My friends take occasion to remind me that paralysis has no where come upon me; that I can see to read and write without glasses, that my hearing is perfect, and that touch, taste and smell require no aid."

And yet with such perfection of physical senses, in scarcely more than two weeks he was dead.

The time is too short, the space too limited, to consider with any justice and completeness Dr. Wright's life and character: but this duty to the memory of my departed friend I shall endeavor to do at an early day.

Among the resolutions adopted by the staff of the Commercial Hospital, the following strikes me as being preëminently proper and truthful:

*"Resolved,* That as a teacher and practitioner he possessed great capabilities, and will be always regarded as one of the ablest men of his time."

He did, indeed, possess great capabilities as a teacher and practitioner. In his lectures he was clear, simple, strong. Whatever knowledge he had was thorough, not superficial. Without any special graces of elocution he could always interest, while he never failed to instruct a class. An old Latin proverb runs, *Cave ab homine unius libri*. If Dr. Wright was not a man of large reading and various culture, there was one of nature's books which he knew thoroughly, and that was practical obstetrics. He did his own thinking, his own observing, and had enough skepticism, if not to reject, at least not to accept that which he did not witness in his own experience. His prize essay upon "Cephalic Version," is one of the most important contributions to American obstetrics. It is more glory to have written that than to have invented some new form of forceps, or uterine speculum, or hysterotome.

As a man he was upright, just, generous, caring not for the accumulation of wealth, and so he died after fifty six years of work comparatively poor. There was enough of the positive in him to make him an earnest friend and a resolute foe. A man of great energy and fertile in resources, he was a leader, and generally led wisely and successfully.

At the grave's mouth the enmities begotten of the jealousies, the mistakes, the strifes and struggles of men, perish; the lips that are sealed in death can have cast upon them no reproach. And so Dr. Wright, who had been engaged in too

many contests, too many prolonged struggles for hospital or medical college supremacies or possessions, not to have made many foes, will not have thrown upon his coffin a single stone, or resting upon his name a single stain. I knew him as an honorable, upright, just man, a kind friend, faithful in all circumstances of life—never a courtier, never a hypocrite, his words and acts always in harmony: and to his memory this grateful but imperfect tribute is given.

T. P.

**SYPHILIS: ITS TREATMENT AND CURABILITY.**—Dr. T. S. Galbraith, Seymour, Ind., sends us the following communication, emphasizing the importance of certain points in the treatment of syphilis:

The poison of syphilis is only known by its effects. The persistent efforts of the microscopist and chemist have failed to determine its exact nature. However, recent investigations render it probable that the virus of syphilis is conveyed by means of degraded cells originally derived from healthy human elements, which in their changed condition are incapable of developing normal tissue, but possess the power of amœboid movement and proliferation. When normal germinal cells are brought in contact with those degraded by the syphilitic influence a similar degradation is imparted to them, and by the lymph channels the diseased cells are conveyed to the lymphatic glands, and after a variable period of incubation the entire system is contaminated; then a succession of symptoms follow, known as secondary or constitutional syphilis.

It is stated by excellent authority (Otis), that "the virus of syphilis has no erosive properties, and that germinal cells from one source or organism can not come in contact with those of an independent organism without a breach of tissue." If this be true, it is difficult to account for the ready propagation and general prevalence of the disease. We are prepared to admit that the syphilitic poison is not erosive, from the fact that the victim is usually ignorant of harm until the first incubation period has passed and the initial papula appears. But infection can certainly take place without a breach of tissue.

It is entirely probable that the vascular turgescence accompanying the venereal act is sufficient to admit the commingling of germinal cells, and contamination of a healthy organism either by amœboid or endosmotic action. All the secretions of syphilitic lesions and the blood during the active stage of syphilis contain degraded germinal cells, and are capable of communicating the disease. The active stage of syphilis is usually from one to two years, and much longer if untreated. The primary and secondary periods are attended with a peculiar cellular infiltration of superficial tissue and enlargement of the lymphatic glands. The various syphilides that appear on the skin and mucous membranes during the early stages of syphilis tend to pass away spontaneously, without leaving any visible marks of their former site or existence. But induration and hyperplasia of the lymphatic glands is the most common and characteristic indication of the active and infectious period of the disease. The tertiary or late manifestations of syphilis are characterized by gummous infiltration, usually of the deeply-seated tissues. No organ or structure of the body is exempt from this peculiar and destructive process. However, these dangerous and formidable lesions are not regarded as due to the direct action of the syphilitic poison, but are the result of a susceptibility imparted to the tissues by the virulence of the antecedent syphilis, and are excited or developed by extraneous influences. Secretions from these lesions are not infectious; neither can the disease in this stage be transmitted by inheritance.

In the treatment of the active stage of syphilis, mercury is the only known antidote. Jonathan Hutchison says that "if three grains of gray powder be given three times a day during the existence of the primary sore, the poison of syphilis will be destroyed and secondary symptoms will not appear." Dr. A. Fournier is of the opinion "that the *omission* of mercury during the secondary stage is the most important cause of tertiary disease."

The extreme views of eminent syphilographers may not be sustained by clinical experience, but that mercury in some of

its forms is the most important remedy we possess in the treatment of the early stages of syphilis, is now generally conceded by a great majority of the most competent observers. But the preparation of the drug that is best adapted to each individual case, the method of administration and the time of its continuance, are questions of the greatest importance, and upon their solution will depend our success or failure in the treatment of syphilis.

General treatment with mercury should be commenced as soon as the diagnosis is positively made. And it should not be undertaken lightly: the patient ought to be impressed with the importance and necessity of a thorough and long continued course of treatment. The preparation of the drug that is selected is not material, but the proto-iodide is a good one, and one-fourth or one-fifth of a grain is a proper dose to begin with. The tolerance of the medicine must be tested in each case. It is a safe rule to obtain as near as possible the physiological action of mercury on the system, and at the same time avoid it. Experience has well shown that the best results are accomplished by the long continuance of mercury in small quantities; in that way its antidotal and alterative powers are fully realized, and its irritant and deleterious effects are avoided. Occasional intermissions may be allowed, but as a rule treatment should be continued for at least two years. If, at the end of that time, a careful examination fails to find any glandular enlargements or other evidences of active syphilis, treatment may safely be left off and the patient kept under observation for another year; during which time, if the disease has not been entirely eliminated, new symptoms will be developed and treatment must again be resumed. When syphilis is untreated or treated irregularly, a period of latency sometimes occurs which is difficult to explain, unless Virchow is correct when he says:—"The dyscrasia of syphilis is only temporary, and reinfection may occur from time to time from certain depôts in the body."

In no disease that we are called upon to treat is it so important that the strictest hygienic rules should be observed.

All vicious and irregular habits must be corrected; that great emunctory of the body (the skin) must be kept in the best possible condition. A warm bath, twice a week, should constitute a part of the regular treatment. Exposure to cold is especially to be avoided. I lost a patient a few months ago from syphilitic paraplegia, which I think was brought on by exposure to severe cold weather during last January.

Of the sequelæ or tertiary stage, I will only say that the disease known as tertiary syphilis is seldom if ever seen, except in cases that have been neglected or improperly treated. But when it does occur, we possess a sovereign remedy in the iodides, however. The disease in this form is not so amenable to treatment as the earlier stages; the prognosis is always more or less grave in proportion to the importance of the structures involved and the extent of the lesion.

TRI-STATE MEDICAL SOCIETY.—According to the announcement by Dr. A. M. Owen, chairman of committee of arrangements, the above young and flourishing society will meet in Evansville, Ind., on the second Tuesday of next November. The prospect now is that it will be a very large and interesting assembly of representative medical men.

MEDICAL ABSURDITIES.—Dr. William E. Brandt, Hanover, Ind., has sent us the following:

*Dr. Parvin*.—Inclosed please find a few prescriptions extracted from a book of great repute in its day, "Etmuller's London Practice of Physic, 1690." ("Shade of Luke! stomachs turn pale at thought of such rebuke.")

*For the Strangury*.—"The cure in general is performed by astringents, especially the decoction of calamint, agrimony and mint in wine; the powders of galangal, aloes wood, myrrh, frankincense, gum arabic, and mastic. The most noted species are the *throat of a cock roasted*, pounded, and given to a dram in wine; the powder of a *burnt or calcin'd hedge-hog*; the powder called *medulla saxorum*; the inner tunicle of a hen's *ventricle*, which when dried becomes hard like horn;



the fish found in the belly of a pike; the powder of a sow's womb; the powder of hogs' hoofs; the powder of dried mice; and the dung of a she-goat."

*For a Polypus*—"If a polypus have any tendency to a cancer, it ought not to be meddled with. If it be ulcerated, apply the water or ashes of frogs, powder of crabs, lead melted and dulcified, the crocus of steel, and such like."

*For a defective ferment of the kidneys*—"We exhibit the sharp saline diuretics, mixed with the temperate oily ingredients; especially the decoction of garlic heads, the seed of hedge mustard, given to a dram in wine, the juice of parsnips, the spirit and *salt of urine*; Amelungins's nephritic tincture, prepared from tartar, nitre, antimony, and the *solar flint stones*; the carminative spirit, the volatile spirit of tartar; the spirit of sal ammoniac, the volatile salt or distilled oil of amber; the spirit or juice of *earth worms*; the powder, juice, and infusion of *wood lice*; the infusion of Spanish flies in wine, or their diuretic essence, prepared with the tincture of tartar; *the infusion of horses' dung in Rhenish wine*; the *urine of a goat*; crab's eyes mixed with wine or vinegar; the decoctions of red vetches, chervil, madder, or St. John's work; *the shells of hens' eggs*, or rather those of *ostrich eggs*, given to a dram, or dissolved in spirit of salt; the powder of snails' shells, dissolved in like manner."

HONORS TO THE MEMORY OF DR. CRAWFORD W. LONG.—On Friday, August 22d, Atlanta, Georgia, witnessed a most interesting event, namely, the presentation of a portrait of the late Dr. Crawford W. Long to the Legislature of Georgia. Mr. H. L. Stuart, of New York, was the donor, Senator John B. Gordon made the presentation speech, and that of acceptance was made by Col. Benjamin C. Yancey. It seems well established that Dr. Long, living in Jefferson, a small village in Jackson county, Georgia, in March, 1842, removed a tumor painlessly from the neck of Mr. Venable, the subject being under the anesthetic influence of sulphuric ether. Both in that year and in 1843, other similar experiments were made by Dr. Long.